			1 - For State Registrar		State o	f Maryla	nd / Depa		nt of H	ealth a	and M	lental Hy		711111		
	Dhunia	:	1. Decedent's Name (First, M	iddle, Last)								2. Date of De		av Vone	3. Time of Dea	ith
	Physic /Medi		Eunice Vir	ginia	Caste	elow						Janua	ry "	ľo, 2ďď7	2025	M
	Exami		4a. Facility Name (If not instit	ution, give s	street and nur	nber)		4b. City,	Town, or	Location of	of Death		4	c. County of Death	1	
			Harford Mem							Grac				Harford		
	Funeral		5. Social Security Number	6. Sex	M 2⊠F	7. Age (In yrs 90	. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Month, Di 3/22/1	rth ay, Yea	9. Birth	place (State or Fountry)	-
	Director		203-10-9396 Usual Residence of Deceden			90	Yrs.				<u> </u>	3/22/1	916	Penr	sýlvania	
	land		10a. State 10b. Cou			10c. C	ity, Town or Lo	ocation			-				10d. Inside City Li	mits
	Mary Lesh	ō	MD	Harfo	ord		Churc	hvill	.e						1 ☐ Yes 2%	
	r 28s	rec	10e. Street and Number					10f. Zip	Code				10g. C	Citizen of What Cou	intry?	
	h wit	E D	11 Calvary 1	Road				2	1028					U.S.A.	,	
	eep dee	Funeral Director	11. Marital Status		12. Was Dece Armed Fo	dent Ever in l	J.S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - Amer		
ي	or its	E	1 ☐ Never Married 2 ☐ I		1 ☐ Yes If Yes, Giv	2X No	1	ii res, spe 1 □ Yes		Specify:		Hican, etc.)		Black, White		
	ural'.	d by	3℃ Widowed 4 Divor	ced	Year or Da	ates:		1 1 103	212410	эрвспу.				Specify: Wh	ite	
rç	nat nat	Completed	15. Dece (Specify only hi	dent's Educ ghest grade			16a. Dece	dent's Usu kind of wo DO NOT u	al Occupa nk done d	tion uring mos	t of work	ing	16b.	Kind of Business/l	ndustry	
5	the series	рщ	Elementary/Secondary (0-1 12	2)	College (1	-4or 5+)	Nurs		se retirea,				NT	and in a		
7	filed Hygi nt,		17. Father's Name (First, Midd	dle, Last)	<u> </u>		Nuls	<u> </u>		18. Mothe	er's Name	(First, Middle		ırsing		
2	id be ental ked o	To Be	Ross McKleve	ЭУ								ie Rhoa				
2	shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relati	onship (Ty)	oe, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	al Route Numb	er, City	or Town, State, Zi	<sup>ip Code)</sup> 21078	-
\ 2	and 2 alth a 27 is		Karen Berger	(Adopt	ted gra	anddaug	ghter)	426	Quak	er Bo	otton	Rd. H	avre	e de Grac	e, MD 78	
S S	of He		20a. Method of Disposition	0 00			Place of Dispo	sition (Nai	ne of other place	,	C	Date	20c. I	Location - City or T	own, State	
ಎಂಡ Timor	Pag ment ant: t		1   Burial 2 □ Cremati  □ Donation 5 □ Othe		emoval from t		ton Cer				/15/	07	Elk	cton, Mar	yland	
ವಿರವರ Baltimore. Marvland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depermit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. The Medical Exact ferms 23 or 28s-1 show eny injury or other traumatic event, the Medical Exact arms the notified at Once.		21. Signature of Funeral Serv	ice License	99 / /		22	2. Name ar	d Addres	s of Facilit	ly T	hinoma 1	LLon	oo 12 7		
-	aos a		Kustent	try	-UW	HESD	U							e. P.A.		
1			23a. Part1. Enter the disease shock, or heart failure.	, or complic list only on	e cause on ea	used the dea ach line.	th. Do not ent	er the mod	le of dying	, such as	cardiac o	or respiratory a	ırrest,		Approximate Interval Between	1
	Physician		Immediate Cause (Final disease or condition	a	51	alu.	3 2	pile	ple	ees				2	Onset and Death	1
	/Medical Examiner		resulting in death)		Due to (	or as a conse			•							
		-	Sequentially list conditions.	b.		ii ds a consec	-8									
er.	nsit	ul u	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>₹</b>	Due to (	or as a consec	quence (ii).									
\ \( \text{\tin}\text{\tetx{\text{\tetx{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\texi}\text{\text{\text{\texi}\tex{\text{\text{\texi}\text{\text{\texi}\text{\texi}\texit{\t	be executed sicien and burial-transit	Examine	that initiated events resulting in death) Last	c.	Due to (d	or as a consec	quence of):									-
دد	S S S S	call		d												
<b>\</b> 9	tificat ig phy as th	ed		0.			100									
Box	death certifica attending ph	NZ.	IF FEMALE: 23b. Was decedent pregnant	23	Bc. If yes, outo			3						23d. Date of deliv	rery	
	deat na att	sicia	in the past 12 months?			nth 2 ☐ Feta ant at time of o		Ectopic pr Other (sp						Month	Day Year	
P.O.	et the	Physician/Med	9 Unknown									T				
	res th iigned be d	ρ	Part II. Other significant cond	litions cont ・・	tributing to de	ath but not res	sulting in the ur	nderlying c	ause give	n in Part I.					the cause of death	
(aste low Vital Records,	requi	Completed	<u> </u>		1.		,					1	Yes 2	2. Aŭ No 3. □ Pro 	bably 4 □Unkno	own
Casta)	e law has b	nple.										24a. Was	psy	24b. Were auto	opsy findings available	able
28 E	icate						_					1 Yes	ormed? 2∭2 N	death? o 1 ☐ Yes	2 🗆 No	
Vit.	iciar certif	Be	25. Was case referred to med examiner?		ospital: ,				100			Check only	1177			
oţ	Phys r this ral di	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 00 10		ER/Outpatien 28b. Time of			4 🗀 1401				6 ☐Other (Speci	fy)	
o	ding th. fune	흔	1 Natural 5 ☐ Pen	ding stigation	28a. Date o (Month	, Day Year)	Injury	M	8c. Injury Work'	al P es 2∐1		28d. Describe	now inju	ary occurred		
Division of	Atten dear octor	fica	3 ☐ Suicide 6 ☐ Cou	ld not be	28e. Place	of Injury · At h	ome, farm, stre					28f. Location (	Street a	nd Number or Rur	al Route Number	
ă	al or s afte of in b	Certification;	4  Homicide dete	annin 1 <del>0</del> G	buildin	g, etc. (Specia	fy)	, , , , ,	,			City or To			ar riodio ridinoci,	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the I	Medical	29a. Certifier 158 Certification (Check only one)	ying Physi al Examina	cian: To the l ar: On the ba and mann	sış or examına	owledge, death ation and/or inv	occurred estigation,	at the time in my opi	e, date and nion, deat	d place, a	and due to the ed at the time,	cause(s	s) and manner as s nd place, and due t	stated. o the cause(s)	
	To ti To ti	Σ	29b. Signature and title of cert						. License				29d. Da	ate signed (Month,	Day, Year)	
				-	_ N	100			132	-600	7		i	4107 .		
	1		30. Name and address of pers	on who con	npleted cause	of death (Iter	n 23a) (Type, I	Print)	<i>a</i> .		-		,			
			31. Date filed (Month, Day, Yes	17/11/15	amm	n 1106	Kevol	mlur	5+	Jan.	reb	e Gran	LW	n 21078	4-	
	Stat Registra	~	30. Name and address of persons  Committee  31. Date filed (Month, Day, Yes)	8 2007	7	ystrars signa	ALUITO ALUITO	W.								

			For State Registrar	State of Ivial	Cer	tificate of			eg. No. 2	7 01002
	Physici	an	1. Decedent's Name (First, Middle, La					Date of Deat     Month	Day Ye	
	/Medic	al	Thomas  4a. Facility Name (If not institution, given	Eugene	Carney	Ab City Town o	Sr. r Location of Death	JANUARY	15TH, 20	007 17:59 M
	Examin	er	MEMORIAL HOSPITAL	e street and number)		CUMBERLA			ALLEGA	
-	Funeral Director		5. Social Security Number 6. S	IDM 2DF	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jun 21,	Year) 9.	Birthplace (State or Foreign Country) MD
	land ow		10a. State 10b. County	1	0c. City, Town or Lo					10d. Inside City Limits
	e Mary Sa-f sh tiffied	ctor	MD Alleg	any	Cun	berland				1 Yes 2 No
	or 28	<b>Funeral Director</b>	10e. Street and Number			10f. Zip Code	04500	1	0g. Citizen of Wha	
	eath v	eral	120 Massachuse	12. Was Decedent Ev	er in U.S. 13. \	Was Decedent of H	21502 Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	US 14. Race - A	American Indian,
920	be filed within 72 hours after death with the Maryland Hygliene. Id other than "natural", or Items 23a or 28a-f show devent, the Medical Examiner must be notified at	l by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ⚠ Yes 2 □ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 ☐ 🔏 o	an', Mexican', Puèrti Specify:	o Rican, etc.)	Black, V Specify:	white, etc. white
5-0		etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	lent's Usual Occup kind of work done	oation during most of worl d)	king	16b. Kind of Busine	ess/Industry
121	filed within Hygiene. Ither than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Shipp		u)		Tire Com	ipany
d 2	be filed tal Hygi d other event, tl	Be C	17. Father's Name (First, Middle, Last	1)	, <u> </u>				Maiden Surname)	
ylar	should be nd Menta marked matic ev	10 E	Eugene Carne					`	narkle) Ca	
Baltimore, Maryland 21215-0036	nd 2 s llth ar 27 is r trau		19a. Informant's Name/Relationship Mary Kesner	(Type. Print) daug	hter 120	Massacl	husetts	Cum	r, City or Town, Sta berland	MD 21502
more	00		20a. Method of Disposition  1 ☐ Burial 2 ☐ Tremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Dispo cemetery, cree Scarpelli Fu			1/17/2007	20c. Location - City  Cresapt	
Balti	permit. Pages Department of important: If it any injury or once.		21. Signatur 1 Tuneral Service Lice	nsee AM	. 22		ess of Facility Illi Funeral Ho ginia Avenue		nd, MD 21502	
	1		23a. Per 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the one cause on each line	ne death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Ucute		irdial	infarc	tion		Onset and Death
1	/Medical Examiner		resulting in dealth)	Due to (or as a	consequence of):					
	s.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is (Disease or injury)	b. Due to (or as a	consequence of):					
Z.	tificate be executed ig physician and as the burial-transit	Examiner	Cause. Enter Orderlying Cause (Disease or injury that initiated events resulting in death) Last	c						
60,	be execian a		resulting in death) Last	Due to (or as a	consequence of):					
68760,	tificate g physi as the l	edical		d						
.O. Box (	The law requires that the death certifate has been signed by the attending agge 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome por 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	cy		23d. Date o Month	f delivery Day Year
Δ.	s that in ned by a detail		Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
ords	w required been sig should be	ed b	Kenal tall	ure	<del></del>			1 🗆 Y	'es 2 □ No 3[	Probably 4 Unknown
or Vital Records,	e law re has be je 2 sho	Completed by						24a. Was a autop	sy prio	re autopsy findings available r to completion of cause of
alF			OF Management to modical		,		00 Bl ( D	1□ Yes	2⊠No 1□	Yes 2□ No
<u>X</u>	Physician: r this certific ral director, i	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 1 M Inpatien	t 2 ☐ ER/Outpatier	nt 3 DOA Oth	har:	th <i>(Check only or</i> ome 5☐ Resid	ence 6 🗆 Other (	Specify)
100			27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time o				ow injury occurred	
Sio	Attending r death. ector: Afte by the fune	catio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not I	on		M 1 □	Yes 2 □ No			
Division	7 to 1 -	Certification:	4 Homicide determined	building, etc.	y - At home, farm, sti <i>(Specify)</i>	eet, factory, office		City or Tow		or Rural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Ce		thysician: To the best of aminer: On the basis of and manner state	examination and/or in					
	To th withir To th comp	Me	29b. Signature and title of certifier	J		29c. Licens	se number	2	29d. Date signed (	
				my			33280		Jan 16,	2007
_	6		30. Name and address of person with GUPTA, SUNIL K.,	M.D., 625	KENT AVEN		E 101, CU	MBERLAND	, MD 2150	)2
	Sta Regist		31. Date filed (Month, Day, Year)	32. Hegistrar	's Signature	arte				·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Curtis Μ. Gregory 12,2007 5:23A January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Prince Georges (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 □ F 20,1951 Wash., DC 578-64-5707 April Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1X Yes 2 No Waldorf Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 United States 2502 Gittings Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer DC Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Burnes Jack Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 2 Gittings Court Waldorf, Md. 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) Date of Disposition (Name of cemetery, crematory or other place) Jocelyn Curtis/wife 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Riverdale Park Crem. 1/19/07 Riverdale, Md. 21. Signatule of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sylock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im diate Cause (Final disease or condition resulting in death) Ischami Due to (or as a consequence of) Coxcoam if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed es 2 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

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Md.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Me-11 al Examiner must be notified.

Baltimore, Maryland 21215-0036

burial-transit the attending physician and signed by the aid be detached for this

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification: After t

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	

25. Was case examiner?	to	medica
1 ☐ Yes		

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

Hospital:

28a. Date of Injury (Month, Day Year)

1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D28035

29d. Date signed (Month, Day, Year) 01-10-2007

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) A. M.D. 9135 Prs rutaway Rd. #310 BASIRMORMAD TERMORMAD TO M. MD 20735

State Registrar

Medical

31. Date filed (Month, Day, Year)





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 4:27AM CLEAVELAND KATHLEEN 07, 2001 GAIL Januaru /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ivisto 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday Social Security Number **Funeral** Months Days Hours 1□M 2**X**F 15,1943 MARYLAND 63 JUNE Director 214-42-6779 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County a or 28a-f show t be notified at 1 □ Yes 2**X**X0 COBB ISLAND Directo MARYLAND CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with U.S.A. 20625 17163 RUSSELL DRIVE or items 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📈 No Specify. Specify: WHITE ð 3 X Widowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 7-11 STORES STORE CLERK 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) be AMAND ELIZABETH ALLEN GEORGE BRADLEY WHITE Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20625 18955 WICIOMICO RIVER DR., COBB ISLAND, MD 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trace REBECCA LA ROQUE-NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State **Ítimore**, Date 20a Method of Disposition 1XXurial 2 □Cremation 3 □Removal from State MARYLAND VETERANS CEM.1-11-07 | CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Funeral Service License 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Betweer Onset and Deat Immediate Cause (Final week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** curanion Sequentially list conditions bus to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hodgkins Lymphoma The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year for Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 X No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Physician: funeral director 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) or Attending 5 Pending investigation 1 Natural 1 ∏Yes 2 ∏No 24 hours after death. 2 Accident completely filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Hospital Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29d. Date signed (Month), Day, Year) 29b. Signature an mpleted cause of death (Item 23a) (Type, Print) Charles Street LaPlata, MD 20646

Registrar DHMH 17 Rev 1/2001

State

narlene

31. Date filed (Month, Day,

Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 💪 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DAIHL 1005AM **Physician** Lester DAVID 7007 Jon very /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SOHNS HOPKINS HOSPITAL BALTIMORE Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 199-52-5930 1**K**M 2□F 62 Director Usual Residence of Decedent 10d Inside City Limits 10a State 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Shippensburg PA 1 ☐ Yes 2 No Director Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) McClure COMPany College (1-4or 5+) Elementary/Secondary (0-12) Pipe Fitter Welder 12 permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Daihl Delores ester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shippensburg 17257 20b. Place of Disposition (Name of cemetery, crematory or other place) Road Dail 20c. Location - City or Town, State 1-10-07 Smithsbury 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematerium

22. Imme and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee J. L. Davis Fyreal Home 12525 Bradbury Ave. Smithsburg, MO 21783 M01414 LAVIS 20a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ORGAN FAILURE MULTISYSTEM **Physician** 2 /Medical Due to (or as a consequence of) Examiner MBOCISM PUMONART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified VES-600 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEOFF ALLEN, MA 600 NORTH WOLFE STREET MARYCAND SALTIMORE 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-00281 State of Maryland / Department of Health and Mental Hygiene Donna R. Devore Certificate of Death 1- For State Registrar Decedent's Name (First, Middle, Last) Date of Death Time of Deatl Physician/ Month Day January 10, 2007 0746 hrs Medical Examiner Donna Rae DeVore c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** oreign Months Days Hours 6-17-1947 Director 59 1 M 2 X F 214-02-8078 Usual Residence of Decedent 10d. Inside City Limits loc. City, Town or Location 10a State Yes 2 X No 23a or 28a-f show notified at once. Ellerslie MD Allegany after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number USA 21529 10017 DeVore Street 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XNever Married 2 Married Examiner must Yes 2 X No jes I and 2 shoure occ... tof Health and Mental Hygiene if Item 27 is marked other than "natural", or if Item 27 is marked other than "natural", or white Specify If Yes, Give Year Yes 2 X No specify: Widowed δ 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) MD 21215-0036 should be filed within and Mental Hygiene own home homemaker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Erma Bowman or other traumatic event, Be Vernon James DeVore, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 19a. Informant's Name/Relationship (Type, Print ) 133 Stringtown Hollow Rd., Hyndman, PA 15545 Sharon K. DeVore/ sister 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Baltimore, crematory or other place 1 X Burial 2 Cremation 3 Removal from State permit Pages
Department or
Important: I 1/16/2007 LaVale, MD Restlawn Mem. Gardens Donation 5 Other Specify 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 21502 108 Virginia Avenue, Cumberland, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and faflure. List only one cause on each line. /Medical a Coronary Artery Thrombosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical UNPENDED AMENDED physician the burial -68760 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Phy The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ö ŝ 1 Yes 2 V No 3 Probably 4 Unknown End Stage Renal Disease; Diabetes Mellitus Completed Records, 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of death? performed' 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital director æ Other<sub>4</sub> Hospital: 1 DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending the 2 Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City

the Hospital or Attending Physician: - death e Funeral Direct etely filled in by the

Could not be Suicide determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated b Signature and title of certifie

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) January 11, 2007

or Town, State)

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

State Registrar

Medical

31 Date filed (Month, Day, Year)

32 Registrar's Signature

within To the

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1	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7	. Age (In yrs. last birth	Months Days	Hours Min.	8. Date of Birth (Month, Day, JAN 15,	Year)	Birthplace (State or Foreign Country) orth Carolina
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	ylanc how		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
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ē,	f Health item 27 other tr		20a. Method of Disposition	20b. Place of D	Disposition (Name of		Date 2	20c. Location - Cit	y or Town, State
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Baltimore,	permit. Pages 1 Department of H Important: if ite eny injury or ot		21. Signatule of Funeral Service Licensee	The Lations	22. Name and Addre Hicks Home				
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o O	at the de by the a stached f	Physician/Med	1 ☐ Yes 2 ☑ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown	nt at time of death vn	5 ☐ Other (specify) _				ŕ
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<u>~</u>	Physic this ce at dire	To	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Th	patient 2 ER/Outp	patient 3 DOA Ott	ner: 4 Nursing Ho	ome 5 Reside	nce 6 Other (	Specify)
Division of Vital	Attending Physician: r death. sctor: After this certifict by the funeral director,	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month	Injury 28b. Ti Day Year) Inj	me of 28c. Injury Wo	ry at rk?	28d. Describe ho	w injury occurred	
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	spita nours nerai		29a. Certifier 1 Certifying Physician: To the I	est of my knowledge,	death occurred at the ti	me, date and place,	and due to the ca	use(s) and manne	or as stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only one) 2 Medical Examiner: On the base and manner	sis of examination and or stated.	or investigation, in my	opinion, death occur	red at the time, da	ite and place, and	due to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier		29c. Licens		25	d. Date signed (A	
)			▶ Roberta. Montelen	e Me	Doos	53675		1/12/	2007
	5		30. Name and address of person who completed cause						
- 20	-	10	Robert A. Monteleone, M.D. 31. Date filed (Month, Day, Year) 32. Ae	gistrar's Signature	High Street	Suite 2	14, Elkt	on, MD 2	1921
1	Sta Registr		31. Date filed (Month, Day, Year) 32. Re JAN 1 8 2007	www St. A	Grants?				
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DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760.

filled in by the funeral after death. within 24 hours a

To the Funeral C

completely filled

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Medical

29a. Certifier

29b. Signature and title of certifier

State Registrar ed cause of death (Item 23a) (Type, Print)

and manner stated.

29d. Date signed (Month, Day, Year) 2007

11855 Holly L., Wolderf Mb 20601

3. Registrar's Signature

Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 6,2007 **Physician** 5:00 AM ANNA PATRICIA IRWIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES 8065 BENSVILLE ROAD WALDORF If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2XX Months 75 MAR. 27, 1931 Director 463-40-8795 TEXAS Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XIXNo Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 8065 BENSVILLE 20603 ROAD U.S.A. ral", or items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ald No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXo Specify Be Completed by Specify: WHITE **3**□Vidowed 4□Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 TEACHER RICA SCHOOL Pages 1 and 2 should be filed w thrent of Health and Mental Hygie tant: If item 27 Is marked other ti jury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LACY B. ELLISOR ANNIE PEARL WILKS ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LISA TAYMAN-DAUGHTER 8065 BENSVILLE RD., WALDORF, MD 20603 Department of Heali Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State XIXBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) TRINITY MEMORIAL GDNS. 1-10-07 WALDORF, MARYLAND 21. Signature of Furmal Service Licenses M 0 0 4 7 9 2. Name and Address of Facil 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) RAYMOND FUNERAL SERVICE, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a const quence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine I or Attending Physician: The law requires that the death certificate be executed attendeath.

Director: After this certificate has been signed by the attending physician and in by the Innoral director, page 2 should be detached for use as the burial-transit in by the Innoral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD05480 -2007 Dr. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste# 100, WaldorfimD

Registrar

State

31. Date filed (Ment

old line Center,

Registrar's Signature

			For State Registrar	State of Man		artment of H			giene	01010
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4	Physicia		Mildred F	. McGreev	v			Jan.	9, 2007	19:26 M
	/Medic Examin	~	4a Eacility Name (If not institution, give Upper Chesapea			4b. City, Town, or Bel A:			4c. County of Death	1
1825	Funcial		Medical Center 5. Social Security Number 6. Se	7. Age (/	n yrs. last birthday,	If Under 1 Year	If Under 24 Hrs			nptace (State or Foreign
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21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f ahow he Madical Examinat must be nutilled at		15. Decedent's Edu	cation	16a. Dece	edent's Usual Occup e kind of work done	ation	ndeina	16b. Kind of Business/l	ndustry
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薑			21. Signature of Funeral Service Licens		Memoria	1 Garden 22. Name and Addre			enstein Mo	
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	Physician		Immediate Cause (Final disease or condition		RITICH	AL Alt	RTIC	STE	NOSIS	Onset and Death
	/Medical		resulting in death)	Due to (or as a c	consequence of):	FRID				10 400
	Examiner	L	Sequentially list conditions,	b. Due to (or as a c		-12(0	366	CRO	3(3	(0)13
17	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence on).					
	al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
760,	The law requires that the death centificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	cail		d						
99	ntificating physical as the		IC CCMALE.				-	0000		
Вох	th cer lendir r use	an/N	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		☐Ectopic pregnancy	,		23d. Date of deli Month	ivery Day Year
	e dea the at hed fo	Physician/Med	in the past 12 mophts? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of death 5	Other (specify)			1113	54,
P.0	hat th od by detacl	Phy	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause giv	en in Part I. /	23e. Did t	obacco use contribute to	the cause of death?
Records,	w requires that been signed to should be deta	d by	Acute	myoc	andre	e lu	forution	700 10	Yes 2 1 No 3 Pr	obably 4 Unknown
cor	beer beer shou	ete				V		24a. Was	an 24b. Were au	itopsy findings available completion of cause of
Re	he law te has l age 2 s	Completed					<del></del>		psy prior to death? 2 □ Yo 1 □ Yes	/
ta	ysician: The is certificate hadirector, page	a)	25. Was case referred to medical				26. Place of De	eath   Check only		
<b>/</b>	Physici this ce al direc	To B	examiner? 1 Tes 2 10	Hospitaf: 1 Impatient	2 ER/Outpatie	ent 3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Resi	dence 6 Other (Spec	city)
0	Attending Physician: If death. sctor: After this certifica by the funeral director, I	iio	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of frigury (Month, Day	Year) 28b. Time Injury	Wor		28d. Describe	how injury occurred	
sio	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		A. b		Yes 2 □ No	206 ) easting /	Street and Number or B	ural Pauta Number
Division of Vital	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	( - At home, farm, s (Specify)	street, factory, office		City or To	Street and Number or Ru wn, State)	I/a/ Houle Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	aj Ce	29a. Certifier 1 1 certifying Ph	vsician: To the best of	my knowledge, dea	ath occurred at the til	me, date and place	e, and due to the	cause(s) and manner as	s stated.
	a Hos 24 h s Fur letely	Medicai	(Check only 2 Medical Examone)	iner: On the basis of e and manner state	xamination and/or	investigation, in my o	pinion, death occ	curred at the time,	date and place, and due	to the cause(s)
	within To th comp	Me	29b. Signatu e and title of certifier	20.1	1 * -	29c. Licens	e number		29d. Date signed (Mont.	h, Day, Year)
			•	Htteno	two	D	. 164	44	Jan 10	1W2007
	8		30. Hinte and address of person who of	ompleted cause of dea	th (Item 23a) (Type	S. AT	NUOD	Rom	BELF	th 2007 til 21014
Section .	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2. Registrar		els.				

DHMH 17 Rev 1/2001

ORIGINAL

07-00305 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mary Ann Morgan State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) Date of Death Time of Death Physician/ Month Day January 11, 2007 Medical Examiner MARY ALRICKS MORGAN 1030 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 109 South Washington Street Apt A Faston Talbot 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Age (In yrs. last birthday) Months Days Hours Director 215-48-7388 1 M 2 X F 49 NOV. 1, 1957 Country) MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 EASTON TALBOT MD Director 10e. Street and Number 10f. Zip Code \* 10g. Citizen of What Country? USA 109 SOUTH WASHINGTON ST APT. A 21601 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No Widowed 4 X Divorced f Yes. Give Year Yes 2X No specify WHITE Specify ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should be filed within 72 hours 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 th and Mental Hygiene.

27 is marked other that umatic event, the Medis SELF-EMPLOYED HAIRDRESSER 2 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) KATHERINE B. POE Be JOHN M. MORGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD t of Health av. 1200 S€OTIA DR.#108, HYPOLUXO, FL 33462 JOSHUA B. GEIB/SON 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State Department of Important: CHESAPEAKE CREMATION CTR 1/14/2007 STEVENSVILLE, MD Donation 5 Other Specify permit 21. Signature of Funeral Service Li-22. Name and Address of Facility NEWNAM FUNERAL STON, MD 21601 FELLOWS, HELFENBEIN & NEWN 200 S. HARRISON ST EASTON, HOME PA 3a. Part I. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure List only one cause on each line Between Onset and /Medical Cocaine intoxication Death <sup>Ç</sup>xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical sician a X UNPENDED AMENDED 27, 28a-f, #1, perME, perME. g865. 3/1/07 TT Box 68760 IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions o. contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of The law r autopsy ficate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Vital certif 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene After this 1 Yes ö 28a, Date of Injury (Month, Day, Year 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification Natural Pending Yes 2 X No Director: the Fnd 1/11/2007 unk. Fnd 6:10 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 3 6 X Could not be or Town, State) 109 S. Washington St. ston, MD found at home within 24 hours a determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State. Registrar

On VM 17 Rev 1/200

**OCME 2006** 

29b. Signature and title of certific

Tasha Greenberg MD.

31. Date filed (Mont

30. Name and address of person who completed cluse of death (Item 23a)

2001

Assistant Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day. Year)

January 12, 2007

07-00037 Carolyn E. Mitchell

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			I- For State Registrar	Certificate of	Death	Re	.No 200	7 0 1.0 1 /
B. J	Physicia	an/	Decedent's Name (First, Middle,Last)			2. Date of Death Month January 2,		B Time of Death 1
Medi	cal Exami	ner	Carolyn E. Mitchell  4a Facility Name (if not institution, give street and numb	er)	4b. City, Town, or Location of I		4c County of Death	
which can			510 Addison Road South	55	Capitol Heights		Prince George	's
	Funeral Director		579-68-9936 1 M 2 X F	Age (In yrs. last birthday) 54 Yrs	If Under 1 Year If Under 2 Months Days Hours	24Hrs B Date of Birth Min. 02/26/	(MM/DD/YYYY) 9. Birt Foreig Coi	
	Maryland 28a-f show any d at once.	ctor	Usual Residence of Decedent  10a State  10b. County  Maryland Prince George's  10e. Street and Number	10c. City, Town or Locat		l Heights	g. Citizen of What Cour	10d. Inside City Limits 1 X Yes 2 No
	ith the \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	uneral Director	600 Addison Road Sout  11. Marital Status  1 X Never Married 2 Married Armed Force	ent Ever in U.S. 13. Wa	2074: as Decedent of Hispanic Origin res, specify Cuban, Mexican, F	? (Specify Yes or No-	United 14. Race - Ameri White, etc.	
	11215-0036 Id be filed within 72 hours after death wi Aental Hygiene araked other than "natural", or items event, the Medical Examiner must be	d by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15 Decedent's Education (Specify only highest grade or Dates).	completed) 16a. Deceder	Yes 2 No specify nt's Usual Occupation (Give kir		Specify B	1ack ndustry
	ID 21215-0036 Should be filed within 72 hours after and Mental Hygiene and Mental Hygiene 77 is marked other than "natural", natic event, the Medical Examiner	Complete	Elementary/Secondary (0-12) College (1-4  12th  17. Father's Name (First, Middle, Last)	or 5+)	Keypunch Oper:		Priva	te
	D 21215-0036 should be filed within and Mental Hygiene 7 is marked other tha artic event, the Medic	Be C	Joe B. Mitchell			Conn	ie Bright	
	D 21 should I and Mer ' is man		19a. Informant's Name/Relationship (Type, Print )	19b Mailin	g Address (Street and Numb			
	re, M s I and 2 f Health If item 2 er traun		Sean A. Mitchell/Son  20a Method of Disposition  1 X Burial 2 Cremation 3 Removal from	State crematory or of	TCTK	Date	20c. Location - City or	Town, State
	Baltimore, permit. Pages l at Department of Hee Important: If ite		4 Donation 5 Other Specify. 21 Signature of Funeral Service Licensee	22.	National Mem	Stewart 1	Funeral Hom	e
	Physician		John T. Stewart, III (per DVR)  23a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line	sed the death. Do not enter	4001 Benning 1 the mode of dying, such as car	Kd., NE Warred arreduced arreduced to the Market Market Warred arreduced to the Market	est, shock, or heart	Approximate Interval Between Onset and
-	/Medical Examiner			ury complicated onsequence of):	by hypothermia			Death
· .	ed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
	760, icate be executed physician and the burial - transit	Medical	X UNPENDED X AMENDED #	21.perFH.23a.27.	.28a-f, perME, g86	53. 1/26/07 T	Г	
	68 certif nding se as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, ou	come of pregnancy  2 From the attime of death 5 0	etal death 3 Ectopic pather (Specify)		23d Date of delivery	Day Year
	- 8 g 5	_	Part II. Other significant conditions contributing to d	eath but not resulting in the	underlying cause given in Part		bacco use contribute to	
	cords law requi has been 2 should	Completed				24a. Was a autop perfor 1 🗸 Yes	sy prior to o med? death?	topsy findings available completion of cause of
		å	25. Was case referred to medical examiner?	atient 2 ER/Outpatier	26.Place of Death (0		Residence 6 🗸 Othe	r Scana
#2	Of ng Ph Nfter t Uneral	ation: To	1 Ves 2 No 28a. Date of (Month, D) 27. Manner of Death 28a. Date of (Month, D) 2 X Accident Investigation Fnd 1/	Injury 28b. Time of ay.Year)	Injury 28c. Injury at Work?	Pall with environment	now injury occurred  n exposure to  ental temperat	cold
	Division Hospital or Attendi 24 hours after death Funeral Director: /	Certification:	3 Suicide 6 Could not be determined (Specify)	outside single f		Capitol I	Street and Number or Rutate) 510 Addiscutate) 510 Addiscutate MD	
	To the Hos within 24 h To the Fm completely	Medical	29a Certifier (Check only 1 Certifying Physician: To the best of one) 2 ✓ Medical Examiner: On the basis of and manner sta  29b Signature and title of certifier	examination and/or investig	urred at the time, date and place ation, in my opinion, death occ 29c. License number	ce, and due to the caus urred at the time, date	e(s) and manner as state and place, and due to the 29d. Date signed (Mo	ne cause(s)
		2	Carol Halla		O.C.M.E.		January 3, 2007	, 567, 7007)
	20		30. Name and address of person who completed cause Carol Allan, MD Assistant Medical E		Street, Baltimore, MD	21201		
	S Regi:	State strai	31 Date filed (Manth) Programmer) 132. Reg	strar's Signature				

07-001	182
Debra	Marshman

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ January 7, 2007 0223 hrs Medical Examiner Debra Marshman 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince George's If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Foreign Director Cwarsh., DC 224-02-1208 02/06/1962 2 X F Usual Residence of Decedent 10d Inside City Limits 10a State 10b. County 10c City, Town or Location Yes 2 No 28a-f shov Capitol Heights Maryland Prince George's Director 10e. Street and Number 10g Citizen of What Country notified at 1527 Nova Avenue 20743 United States 23a Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 11. Marital Status 12. Was Decedent Ever in U.S. or items White, etc African Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No 4 X Divorced 1 Yes 2X No specify American Widowed Yes, Give Year Examiner 2 or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "1 pr other traumatic event, the Medical E. Baltimore, MD 21215-0036 12th Cardiologist Cardiovascular Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Mae Sutton Charles Holton 2 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lat<u>ia Marshman / Daughter</u> Capitol Heights. MD Nova Ave 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit Page
Department o
Important:
injury or oth 1/15/2007 Landover, MD Donation 5 Other Specify Memorial Park 21. Signature of Funeral Service Licensee Stewart Funeral Home DC Benning Rd., NEWash. . I Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** re. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Bronchopneumonia Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and Physician/Medical X UNPENDED #23a,PII,27,perME, 1/24/07 TT Box 68760, 23c. If ves. outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Ectopic pregnancy Live birth Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.O. ģ Yes 2 No 3 Probably 4 V Unknown Liver cirrhosis, Hepatic steatosis Completed Division of Vital Records, s been s 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Other<sub>4</sub> Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: within 24 hours after uca...

To the Funeral Director: A 1 X Natural 1 Yes 2 No 5 Pending Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 3 Could not be Suicide Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 7, 2007 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Month, Day Year) State Registrar

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Cynthia Kutther-Sands, ND

01A

Marshall

parte

Kuttner Sand no

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type-Print)
Cynthia Kutther-Sands ND 14214 Paradise Church Road, Hagerstown Maryland

29c. License number

Vanuary

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		1. Decedant's Nama (First, Middle, Last	1)				2. Deta of Deat Month	n	Year 3	3. Tima of Death			
н	Physician		WILLIAM	JOSEPH C	TT. JR.		JANUAR	Day 12.20	l l	1:55 AM			
	/Medical Examiner	4a Facility Name (If not institution, giva				4b. City, Town, or Lo	cation of Deeth	4c. County	of Death				
		16167 KELBAUGH	RD.			THURMON	$\mathbf{T}_{m{\ell}}$	FRE	DERICK				
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	ter death with the Maryler them 23e or 25e-f show the matter of all them and the matter at all them at a land at a l	MD FREDE	KICK		THURMONT  10f. Zip Code		10	10g. Citizen of What Country?					
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	fier death v r floms 23a finer muni Funerai	16167 KELBAUGH 1	12. Was Dacadant E	var in U,S.	21788 3. Was Dacedant of	Hispanic Origin? (Spa pan, Mexicen, Puarto I	cify Yas or No-		- Amarican				
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215-0036	ed within 72 hours efter death with the Maryland Wilson. Wilson "naturel", or flems 23a or 28a-f show it, the Medical Examinar must be notified at Completed by Funeral Director	15. Decedent's Edu (Specify only highast grad	ucetion da complatad)	16e. D	acedant's Usual Occu	pation during most of working ed)	ng	16b. Kind of Bu	sinass/Indus	try			
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and	Bēgs ₩	17. Father's Nama (First, Middla, Last)				18. Mothar's Name	(First, Middle, n	raidan Sumam	11/				
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	Heell Heel tem 2 other	STEFANIE M. RINE:	S/DAUGHTER	20b. Place of D	TREETOP :		RFIELD, Date	PA 17	P. 601, 101	, State			
5	6 = 5	1 Burial 2 ☐ Cremation 3 ☐ F			crematory or other pla		c 10000						
Baltimore,	nit. Pe ertmen prtant: injury B.	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	0 0	NEW ST	. JOSEPH S	ass of Facility	6/2007	EMMITSI	1750	MD.			
Ba	Depert Personal Perso	l d in	Ib Va.				SKILES E						
		230 Party Enter the disease or compl	Lipations that sousand	the death. Do not		AIN ST., E							
	Obveision	23a. Part. Entar tha disaesa, or compl sharos, or haart failure. List only o	one causa on aach line	a.	A /				Int Oi	pproximata terval Between nset and Daath			
	Physician /Medical	Immediata Cause (Final	Brad	nhann.	1 Chan	0 10.1	d-			Near			
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on	Attending in death.  Sctor: After by the fune	1 ∑Naturel 5 ☐ Panding 2 ☐ Accidant invastigation	(Month, Day	Yaar) Inju		ork? ]Yes 2□No							
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Ö	tal or Attending P rs efter death. al Director: After t led in by the funer: Certification;	1 Homoda	building, atc.	Ореспу			G.I.J G. 1 G.I.						
	To the Hospital or Attending Is within 24 hours slet death. To the Funeral Director: After completely filled in by the funeral Medical Certification.		reician: To the best of										
	the H vin 24 the F nplete	one)	and manner stat										
	Vithin Com	29b. Signatura and title of certifier	( a 1	1. 1/1/1	29c. Lican	isa number	2	9d. Data signad	i (MONTA, DA)	y, 1881)			
•		P Ulla	M	MANI	)	210102		JANUARY	12,	2007			
	12	30. Neme end address of person who co	omplatad causa of de	eth (Item 23a) (Ty	pe, Print)								
		ALAN CARROLL, 31. Data filed (Month, Day, Year)	M. D 310	S SETC	N AVE., EM	MITSBURG,	MD. 217	27					
	State Registrar	40.44	107 Sanagistia	J. J. J.	booker								

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eginald V. Ormoi	1- R	State of Maryland / Department of Health and Mental  1- For State  Certificate of Death  Registrar	F	Reg No. 200	7 01010
Physician Medical Examine	/ 1 er	1. Decedent's Name (First, Middle, Last)  Reginald V. Ormond	2. Date of De Month January 7	Day Year 7, 2007	3. Time of Death 0909 hrs
	4	4a. Facility Name (if not institution, give street and number)  Doctors Community Hospital  4b. City. Town, or Location of De	ath	4c. County of Death Prince George	's
Funeral Director		579-80-8230   1X M 2 F   46 Yrs.	8. Date of 8 ylin. 9/16	/60 9. Birth (MM/DD/YYYY) 9. Birth Foreig	
th the Maryland 23a or 28a-f show any notified at once.	חופכוסו	Usual Residence of Decedent  10a. State  Md. Prince George's Greenbelt  10e. Street and Number  7726 Hanover Parkway # T-2  10c. City, Town or Location  Greenbelt  20770		10g. Citizen of What Cour	
2 hours after death wi		12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puelling Yes, Specify Cuban,	of work done	White, et Af	rican- erican ndustry
	20	17. Father's Name (First, Middle, Last)  Jesse Thomas Ormond  Nac	omi Phil	, Maiden Surname)	<u> </u>
MD 21 ad 2 should B atth and Mer m 27 is mar aumatic eve	2	19a. Informant's Name/Relationship (Type, Print)  Naomi Phillips Ormond/Mother  19b. Mailing Address (Street and Number 5178 Camino Del North		a Vista,Ariz	ona85635
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is ru injury or other traumatir		4 Donation 5 Other Specify.	Date /13/07	Landover,	Md.
		21. Signature of Funeral Service Licenses  22. Name and Address of Facility 4925 Burroughs  23a. Paryl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			, D.C. 20019 Approximate Interval
Physician /Medical Examiner		23a. Paryl. Enter the disease, or complications mat caused the death. Do not enter the mode or dying, such as calculated failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		inest, shock, or near	Between Onset and Death
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d ansit	Exam	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	· ·		
60, e be executed ysician and burial - transit	edical	X UNPENDED #23a,27,perME, g863, 1/23/07 TT		23d Date of deliver	
Box 68760, e death certificate be the attending physic ed for use as the burner.	- 1	IF FEMALE: 23b Was decedent pregnant in the past 12 months?  23c If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	egnancy		V Day Year
P.O. B es that the d	<u>S</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to	the cause of death?
cords, aw requir	Completed		1 Yes	opsy prior to of death?	otopsy findings available completion of cause of the second secon
/ital Rec	Be	25 Was case referred to medical examiner?  1 ✓ Yes 2 No   26.Place of Death (Chery 1)    Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Othery 1 No.	eck only one) ursing Home 5	Residence 6 Othe	r.
ion of \ tending Phy eath for: After th the funeral	ation: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation  28a Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No		e how injury occurred	
Division pital or Attency urs after death eral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify)	28f. Location or Town	n (Street and Number or Ru , State)	iral Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca red at the time, da	tuse(s) and manner as stat te and place, and due to th	ed ne cause(s)
F > F 0	ž	29b Signature and title of certifier  29c License number  O.C.M.E.		January 8, 2007	nth, Day, Year)
CR	}	30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
Sta Registi	ite	E			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Perdew JANUARY 2007 0759 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sep 12, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director MD 80 212-24-1896 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other than matte event, the Michal Examiner must be notified at any Injury or other traumatte event, the Michal Examiner must be notified at Allegany 1√Yes 2 No Director MD Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 912 Maryland Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company 12 <u>Engineering Dept.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecil Jane Hager Boyd Joseph Bruce Boyd ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Skyline Drive WV 26753 brother Carpendale James Boyd Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/14/2007 Scarpelli Funeral Home, P.A. MD 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown 21. Signature 7 Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lamediate Cause (Final disease or condition resulting in death) **Physician** meumor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autonsy within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13,2007 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Memorial Ave, Cumberland, MD 21502 'alk 31. Date filed (Month, Day, Registrar's Signature State Registrar

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ORIGINAL

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miner	4a. Facility Name (If not institution, gi	ive street and number	7)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Deat	h	
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tor	Usual Residence of Decedent		83	3 113.					Sept 24	, 192	23 Ohic	)	
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Directo	10e. Street and Number 10f. Zip C									10g. Citize	en of What Co	untry?	
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କ୍ଷୟ ପ୍ରକ୍ରେମ୍ବର To Be Completed by Physician/Medical Examiner	Immediate Cau (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	is a conseque of pregna 2 Feta at time of d but not resulting tient 2 jury lay Year)	uence of):  uence	DEctopic p Other (sp	oregnancy pecify)  OA Othe 28c. Injury Work 1 1 Y	26. Place  26. Place  27. 4 Nu  28. vec  4 res  29. vec  4 res  20. vec  4 res  20. vec  4 res  20. vec  4 res  4	e of Death	23e. Did 1 1 24a. Was auto perfection of the control of the contro	23 obacco use Yes 2  an appropried? 25No one) dence 6  how injury of the control	id. Date of deliment of the Month of the Contribute to No. 3 Proceed the Month of t	Approximatinterval Bet Onset and I onset a	older Death Year death Inkno availa ause
To Be Completed by Physician/Medical Examiner	Immediate Cau (Final disease or condition resulting in death)  Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a b. Due to (or a d. Due to (or a d	is a conseque of pregna 2 Feta at time of d but not resulting tient 2 jury lay Year)	uence of):  uence	DEctopic p Other (sp  anderlying of the set, factor the occurred westigation	oregnancy pecify)  Cause give  OA Othe 28c. Injury Work 1 \( \) Ty, office	g, such as en in Part!  26. Place at at Yes 2 □	e of Death	23e. Did 1 1 24a. Was auto perfection of the control of the contro	23  obacco use Yes 2   an psy primed? 252No one) dence 6   how injury cause(s) ai date and p	id. Date of deliment in Month  a contribute to Month  24b. Were au prior to death? 1 Yes  Other (Specoccurred  Number or Rund manner as ilace, and due	Approximat Interval Bet Onset and I onset	older Death Year death Inkno availa ause
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କ୍ଷ ଅ cation: To Be Completed by Physician/Medical Examiner	Immediate Cau (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a b. Due to (or a d. Due to (or a d	iline.  Is a conseque of pregna 2   Feta at time of d but not resulting large at the consequence of the consequence of pregna 2   Feta at time of d but not resulting large at the consequence of the conse	uence of):  uence	DEctopic p Other (sp  at 3 Do  M eet, factor  h occurred vestigation	oregnancy pecify)  OA Othe 28c. Injury Work 1 1 Yry, office	an in Part II	of Death	23e. Did 1 1  24a. Was auto perfe 1   Yes auto perfe 28d. Describe 28f. Location (City or To and due to the ed at the time,	23 obacco use Yes 2  psy rmed? 2  Street and wn, State)  cause(s) at date and p  29d. Date	dd. Date of deliment of the Month of the Contribute to the Contrib	Approximat Interval Bet Onset and I onset	older (1) the week of the control of
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State of Maryland / Department of Health and Mental Hygien ( For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician Emilia** Parrish 7,006,0 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 211 Virginia Avenue Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Jan 14, 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 □ XF 237-22-3875 86 Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location Cumberland County Allegany 10d. Inside City Limits d other then "neturel", or iteme 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 211 Virginia Avenue 21502 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status int. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. crient: if Item 27 is marked other then "neturel", or its injury or other traumatic event, the Medical Examina. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: 1□Yes 2□No Baltimore, Maryland 21215-0036 Specify: white þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Congressional Secretary U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emilio Matzzadro Lattie Mathews 19134 Bellhammon Drive Rocky Point NC 28457 <sup>19</sup>Theresa Dean daughter 20b. Place of Disposition (Name of 20a. Method of Disponition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 1/11/2007 Cresaptown MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Furtheral Service Licens permit.
Deportr
Import 22. NamScarpettis Purreral Home, PA TULLED 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death SAD Physician Years /Medical Due to (or as a consequence of): Examiner Zdo Gooepsis Sequentially list conditions, any, leading to finite ediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien end for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Yes 20 No 9 □ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ olemyalgia Elieuxitica 3 Probably 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No Des autopsy 20 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 1 Inpatient Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home this 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d Describe how injury occurred Certification: After t 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: mpletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Describing Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cathlier Medical (Check only one) 29b. Signature and title of cettifier 29d. Date signed (Month, Day, Year) ma person who completed cause of death (Item 23a) (Type, Print) Swite 304 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygieng 🕕 🖯 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Ritchie Georgia 0,000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Allegany 229 Baltimore Avenue Apt 710 Cumberland If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. Apr 3, 1932 Birthplace (State or Foreign
Countries) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗶 F "YVPD 217-28-0750 74 Director Usuel Residence of Decedent the Maryland Town or Location 10d. Inside City Limits 28a-f ehow ir Iteme 23a or 28a-f ehov ilner cust be rectified at MD Allegany Cumberland 1X Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours atter death with 1 Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "naturel", or iteme 23a or 2 empiny or other traumatic event, the Mudical Exp. unscrutt be reques. 229 Baltimore Avenue Apt 710 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married
3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 Specify: white Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kinney Shoe Factory Laborer 18. Mother's Name (First, Middle, Maiden Sumame)
Florence (Starkey) Jones 17. Father's Name (First, Middle, Last) Be James C. Jones 19a, Informant's Name/Relationship *(Type, Print)* Rita Spaid 1997 Yalijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1734 Martinsburg Pike VVinchester VA 22603 daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Forest Glen Cemetery 1/13/2007 Green Spring 4 □ Donation 5 □ Other (Specify) 21. Signatural Finera Service Licensee 22. NamSearbellis Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer **Physician** /Medical Examiner Mctastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a Wasan 2- No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Medical Certification: 5 Pending investigation 1-Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 32 orporate ND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Gorale.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Physician Riggleman 01 11 Ann 07 0435 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS-MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 2, 1933 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 215-34-2602 74 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits ns 23a or 28a-f shov must be notified at WV Mineral Ridgeley 1 ☐ Yes x2 ☐ No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26753 USA 102 Hunt Club Manor Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than " College (1-4or 5+) Elementary/Secondary (0-12) school teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked c Alice Helena Vocke Riggleman Benjamin C. Riggleman ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2741 Westminster Road Ellicott City MD 21043 19a. Informant's Name/Relationship (Type. Print) cousin Joseph Vocke Health sem 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If Its any Injury or o once, 1 ★ Burial 2 Cremation 3 Removal from State 1/13/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nam Sag Addin Fuheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. For 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest proof, or heart failure. List only one chuse or each line. Immediate Cause (Final disease or condition resulting in death) Physician hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): physician a s the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 23 No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes ② No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2KER/Outpatient 3 □ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 10 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🖔 No the ...
within 24 hours after deau..
To the Funeral Director: Aft

Medical 29d. Date signed (Month, Day, Year)

JANUARY 12, 2007 29c. License number 29b. Signature and title of certifier D23774 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24 912 SETON DRIVE CUMBERLAND MARYLAND 21502 T. LIVENGOOD MD 32 Registrar's Signature State Registrar

29a. Certifier

(Check only one)

the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Janice Adele RASEY 2, 2007 January 7:38 a.<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1811 Brightwood Drive Hagerstown Washington 8. Date of Birth (Month, Day, Year)
Jan. 17,1934 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□M 2XF Months Days Hours 72 Yrs 210-26-3981 Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits rthen "naturel", or items 23s or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1811 Brightwood Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Peges 1 and 2 should be filed within nent of Heelth and Mental Hyglene. ant: If Item 27 ie marked other then ' ury or other traumatic event, the Ma Cottege (1-4or 5+) Elementary/Secondary (0-12) homemaker her own home 0 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Richard Kerschner Adele Margaret Lonis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 Brightwood Dr., Hagerstown, Maryland 21740 Watson Rasey - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: If eny injury or pace. Hagerstown Crematory 1/4/07 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 1415 E. Wilson Boulevard, Hagerstown, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause) in each line. Immediate Cause (Finat Cerebellar Dogenera Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of) Examine anding physicien and use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No ğ Month 4☐Pregnant at time of death 5 Other (specify) P.O. | ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 12 Yes 2 🗆 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: ို 1 ☐ Yes 2 ☐ No 2 FR/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Naturat 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer Rd., Hagerstown, MD 21742 ) ANUM FUUS 1514 eath (Item 23a) (Type, Print) 30. Name Jet medical 10 32. Ağgistrar's Signature Registrar

			1 - For State Registrar	State of N	/larylan		artmen rtificat			nd Me	_	giene Reg. No	200	7	010	)23
	Dhusisi		1. Decedent's Name (First, Middle,	Last)						:	2. Date of De Month	ath Da	,	Year	3. Time of	Death
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	lend wo		10a. State 10b. County		10c. Cit	y, Town or Lo	cation								I0d. Inside Cit	y Limits
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	be filed within 72 hours after deeth with the Maryland hal Hygiene. of other than "natural", or Iteme 23a or 28a-f ehow event, the Madical Examinar must be putilized at	Funeral Director	11. Marital Status	12. Was Deceder			Was Deced	lent of Hi	spanic Origin	n? (Spec	ify Yes or No	)-		- Ameri	can Indian,	
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03	e sin	þ	3	If Yes, Give 29 Year or Dates	:		1 □ Yes	2 X No	Specify:				Specify:	Wh	ite	
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yla	2 should be and Mental le marked of	၉	Sam Elizugh Bo			<del>-,</del>			Mar	y Lo	uise C	ulip	her			
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Baltimore,	m O		20a. Method of Disposition 1   Burial 2 □ Cremation 3	3 □Removal from Stat		lace of Dispo emetery, cren	natory or o	ther place		Da				•	wn, State	
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_	70 = 9		Jak Kon	elton.		Ri	ckett	s Fu	ıneral	Hom	e My	ersv	ille	, MI	21773	
		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Betw	veen	
V	Physician	8 7	Immediate Cause (Final disease or condition	End Sta											Onset and D	eath
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9	death certifica e altending ph ed for use as th	Physician/Med	IF FEMALE:													
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P.O.	thet the deathed by the atte	Ph	9 Unknown													
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Ž	hysia his o	၉	1 ☐ Yes 21 No			ER/Outpatien	t 3□ DO	A Othe	<sup>II.</sup> 4 ☐ Nursi	ing Home	5 □ Resid	dence (	Other	(Specit	Home	of
Division of	Viter 1	ö	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury la <i>y</i> Year)	28b. Time of Injury		Bc. Injury Work	at ?	28	d. Describe h	now injur	occurred	i	Daugh	ter
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Ξ	of or Attended the detail Director:	Certification:	4 Homicide determin	ed 200. Flace of I	njury - At ho etc. (Specify	ome, farm, stre	eet, factory	, office		28	f. Location (S City or Tox	Street an vn, State	d Number	or Rura	I Route Numb	er.
Ω	ospital of hours of uneral D			12												
	To the Hospital or At within 24 hours efter or To the Funeral Direct completely filled in by	Medical	(Uneck only 2 Medical E)	Physician: To the bes xaminer: On the basis	t of my kno of examina	wledge, death tion and/or inv	occurred a	at the tim	e, date and printed in the determinant of the deter	place, an	d due to the d	cause(s)	and mann	ner as si	ated.	
	the the	Med	one)  29b. Signature and tille of sprtifier	and manner	stated.											
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_	10		30. Name and address of person w Allen Reilly	, MD; 801	<b>2</b> 611 1	House A		e, Si	uite D	1, F	rederi	ick,	Mary	land	1 21701	
	Sta Registr		31. Date filed (Month, Day, Year)	007 2. Regis	trar's Signa	ture										

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0.7

			For State Registrar	State of Ma		ertificate of			g. No.	UIUZH			
*	Physicia	an l	1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	Day Year	3. Time of Death			
\$1 100	/Medic	al	4a. Facility Name (If not institution, give	street and number	jn	4b. City, Town, o	Location of Death		4c. County of Death				
	Examin	er •	Western Maryland Hospi			Hagerstow	n		Washington				
*	Funeral Director		Social Security Number     6. Security Number		(In yrs. last birthda) 55 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 8,	Y99() 9. Bir	thplace (State or Foreign ountry) yland			
	yland		10a. State 10b. County		10c. City, Town or					10d. Inside City Limits			
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23a or 28e-1 show eumatic event, the Medical Examinar must be natified at		ctor	MD Washington Hagerstown							1 X Yes 2 □ No			
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980	ours after de rat', or Item	þ	11. Marital Status  1 ☐Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give Year or Dates:	o la	. Was Decedent of H If Yes, specify Cuba 1 Yes X No		ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W				
<u>2</u>	"natur	ietec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retired	ation during most of work	ing	16b. Kind of Business	s/Industry			
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Maryland 21215-0036	be filed ital Hygie of other event, II	3e	17. Father's Name (First, Middle, Last)				18. Mother's Name			h			
7	should ind Men marke umatic	2	Paul F. Stumbaugh  19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Ma	ling Address (Street			Stumbaug City or Town, State,				
	s 1 and 2 should f Health and Men ftem 27 is marke other treumatic		Roger L. Stumbaug		MD 21502								
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If item 27 li any injury or other tre		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		Davis Mer	position (Name of ematory or other place norial Cem	Jan.	16,07	20c. Location - City or Cumberland	, MD			
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1 100			23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final										
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٩	Sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  1 Lantle Demenha:  4 ears									
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Box	ath certif	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	I □Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year			
ds, P.O.	uires that the de signed by the a Id be detached f		Part II. Other significant conditions co		en in Part I.	23e. Did tob	to the cause of death?  Probably 4 Unknown						
cor	aw requir s been si 2 should	Completed	Akin	etic m	utism.			24a. Was a		utopsy findings available			
- Be	The lav ate has page 2	Juno:						autops perforr 1 Yes 2	ned? death?	completion of cause of s 2 No			
Vita	icien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		3E BOA O#	26. Place of Deat						
of	p Phys er this eral du	n: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		of 28c. Injur	4X Nursing Fig		nce 6 Other (Spenier injury occurred	ecify)			
sion	ending sath. or: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injun		Yes 2 □ No						
Division of Vital Records,	tel or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulg	iry - At home, farm, :. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or F i, State)	Rural Route Number,			
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai											
	To th To th comp	Z	29b. Signature and title of certifier	29c. License number 29c					9d. Date signed (Mon				
,	Λ		30. Name and address of person who o	ompleted cause of d	nath (Item 22-) (T		ennsylvania		January 13	)			
	3			MALIK	MD		town, MD 21						
	Sta	ite ar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	action							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JÅNÜARY ™10 2007 THELMA NAOMA SOUIRES 7:00p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chester River Manor Chestertown Kent If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. | Hours | Min. | Sept 5 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 212-34-6416 69 Yrs Director 1937 Kentucky Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hygiene.
marked other than "naturel", or tems 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits d other than "naturel", or items 23a or 28a-1 show event, the Medical Examiner must be multiod at MD Queen Anne's Crumpton 1 Yes 2 No Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Lot. 11 Andrew Dr. 21628 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 TNO 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No White If Yes, Give Year or Dates: Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coflege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be filly ment of Heelth and Mental Hy lant: If Item 27 Is marked oth Be Manford Lemaster Carrie Ball 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles M. Squires (husband) P.O. Box 102 Crumpton, MD. 21628 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 St Burial 2 Cremation 3 Removal from State Crumpton Cemetery 1/15/07 Crumpton, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Galena Funeral Home of Stephen 118 West Cross St. Galena, MD. L. Sc 21635 Schaech M00510 Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he int failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition Hdenocarcinoma Physician /Medical resulting in death) Due to (or as a consequence of): Examiner S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the ettending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months?

1 Yes No
9 Unknown 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed: certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: ē 2 1 🗌 Yes 3□ DOA 2 ☐ ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Feath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} within 24 hours e To the Funeral C completely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 1 Wayne D. Benjamin, M.D. 6602 Church Hill Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Marylan		rtment of H tificate of L		ental Hygiei Reg.	2001	01026	
	Physici /Medic		Decedent's Name (First, Middle, Last)     Mildred	Rebecca	Sunde	ergill		2. Date of Death Month January	P <b>y</b> , 2007	3. Time of Death 0852 M	
No.	Examin		4a. Facility Name (If not institution, give st Edenton Retireme	ent Community		Freder				derick	
	Funeral Director			7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Mpnth, Day Ye pril 25,	9. Births 1914 V1	place (State or Foreign htry) rginia	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural, or items 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once.		tor	Usual Residence of Decedent  10a. State 10b. County Maryland Freder		y, Town or Loc		erick		1	0d. Inside City Limits 1 ☐ Yes 2 No	
		Funeral Director	10e. Street and Number 5849 Genesis Lane			10f. Zip Code	21702	10g.	Citizen of What Cour U.S.A		
9036	ours after dea rai', or items Examinar mi	ρ	11. Marital Status 1:  1 □ Never Married 2 □ Married  3 □  Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of Hi i Yes, specify Cuba □ Yes ②∏ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.	
Maryland 21215-0036	d within 72 h jiene. ir than "natu the Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occupa kind of work done o DO NOT use retired, Stered Nu	luring most of workii )	ng	Kind of Business/In		
land	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Samuel Simpso	n			18. Mother's Name	(First, Middle, Maid Bess	ie Steed		
	and 2 sho raith and h 27 is ma er trauma		19a. Informant's Name/Relationship (Type John Roy Sundergil		1				y or Town, State, Zip k, MD 217		
Baltimore,	Pages 1 treet of He tant: If iten		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State Smit	nsburg		y Januar	y 10, 200	Location · City or To 7 Smiths	burg, MD	
Bal	permit Depar Impor eny in	J.	21. Signature of Funeral Service Licensee	Markon	921	-	nd Basfor	d Funeral		MS 21701	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line.  Due to (or as a consequence of the cause of th	eme	n tia	g, shuffil last Cointil ac 20	rkelsfill fildbygarrelsfil	ederick,	Approximate) I. Interval Between Onset and Death	
, ,	icate be executed physician and if the burial-transif	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c Due to (or as a consequence of):							
68760,		edicail	d.								
P.O. Box	Attending Physician: The law requires that the death certificate at death.  a.tr death.  a.tr death.  b. the this certificate has been signed by the attending is the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ NO  9 ☐ Unknown  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ Other (specify)						23d. Date of delivery Month Day Year		
rds, P	w requires that the de been signed by the a should be detached f	ρ	( ) ( ) ( ) ( ) ( )						Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown		
Division of Vital Records,	Physician: The law re this certificate has bee al director, page 2 sho	Completed	Ostros	24a. Was an autopsy performed 1 Yes 2	prior to completion of cause of						
Z ta	certific rector,	Be	25. Was case referred to medical examiner?	spital:		Othe	26. Place of Death	10-200			
ō	Phys or this oral di	2	1 Yes 2 No	1 Inpatient 2	ER/Outpatient 28b. Time of	3 DOA 28c. Injugy	S Nursing Hon	ne 5 ☐ Residence 8d. Describe how in	6 ☐Other (Specify	0	
<u>o</u>	nding ath. r: Afte e fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? 'es 2 □ No				
Divis	tal or Attend s after death al Director: / ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	2	8f. Location (Street City or Town, St.	and Number or Rura ate)	l Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier Check only 2 Medical Examine one)	r: On the best of my known: On the basis of examinate and manner stated.	wledge, death ion and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)	
)	vith To T	2	29b. Signature and title of certifier  AMM	I'm Mi	)	29c. License			Date signed (Month, $10$ , anuary $10$ ,		
	b		30. Name and address of person who com Casper E. Cline	pleted cause of death (Item	23a) (Туре, F 300 Wes	r <sub>int)</sub> t Ninth S	Street, Fi	rederick,	MD 21702		
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 7 200	32. Pegistrar's Signal	turo :		•				
			13418 T 1 700	: Jakobalana Ja							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 2007 Floyd John Shoemaker Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠** M 2□ F 209-12-9748 Director 86 August 18,1920 PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Washington Hancock 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14548 Hollow Road 21750 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Machinist Machine Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Shoemaker, Sr. Mamie Gordon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Achsa J. Shoemaker/Wife</u> 14548 Hollow Road Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/09/07 <u>ittle Cove U.M.</u> Mercersburg. PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street M01414 >wis Grove Funeral Home, P.A. Hancock, MD 21750-0368 Fill. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as IF FEMALE: esn If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ь in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown þ signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate ! 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Hospital or Attending Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Stat

31. Date filed (Month, Day, Year)

JAN I

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

38

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Harold Wixon Taber, Jr. JAI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X1M 2□ F Months Days Hours Min Director 173-22-6711 76 Oct. 12, 1930 Pennsylvania Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10b. County 28a-f show aţ be notified Directo Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must Funeral 13069 Wild Geese Lane 21783 U.S.A.Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. In: If them 27 is marked other than "natural", or ite iny or other traumaft event, the Medical Examiner iny or other traumaft event, the Medical Examiner. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: by Specify: 3 Widowed 4 Divorced White ed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Complet (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Estimator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold W. Taber, Sr. ၉ Evelyn West 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Lucile Henry Taber (Wife) 13069 Wild Geese Lane Smithsburg, Maryland 21783 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Green Hill 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State January 4 Donation 5 Dother (Specify) 2007 Cemetery Waynesboro, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home DAVIS Mol4/4 | 12525 Bradbury Ave. Smithsburg, Maryland 21783 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final **Physician** HRONIE OBSTR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himsulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy certificate I perform 1□ Yes 2DANo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural Injury death, 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Pruneral Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

1 ☐ Yes 2 X No

. 20 M

O

Registrar

State

1110

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

agenbut

Year

8

31. Date filed (Month

			State of Maryland / Dep		Mental Hygien	е					
_		_	Registrar	ertificate of Death	Reg. N	2007 01	029				
- PK	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Y								
	/Medi		Harry Edward White Sr.		anuary 7, 2007 2110 M						
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		c. County of Death					
-			Holy Cross Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda	Silver Sprin  (i) If Under 1 Year   If Under 24 Hrs		ontgomery					
	Funeral Director		117 M 2∏ F	Months Days Hours Min.		9. Birthplace (State Country)	or Foreign				
	rijos editaldes spaldar	\$	235-30-9148		reb.2,19.	25 West VA					
	yland Jow at		10a. State 10b. County 10c. City, Town or	ocation		10d. Inside 0	City Limits				
	a-f sl	cto	VA Alexar	dria		1 <b>□</b> Ye	s 2 No				
	th the or 28 e noi	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?					
	23a ust b		3002 Manning Street	22305	Un	ited States					
	r dez tems er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		14. Race - American Indian, Black, White, etc.					
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Fe	1 Never Married 2 Married 1 XYes 2 No If Yes, Give	1 ☐ Yes 2 X No Specify:	io i iidaii, otai,	Specify:					
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5	in 72 i "na ledic	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation le kind of work done during most of wo DO NOT use retired)	rking 16b. F	Kind of Business/Industry					
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p	filed Hyg other	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle, Maider						
Maryland	ild be lenta rked	To B	George E. White	Lois	Henderson	,					
ary	shou and N s mai			ing Address (Street and Number or Ri		or Town, State, Zip Code)					
Σ	and 2 salth 127 i er tra		Homes E   White To /   154	20 Doveheart L	ane	,					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	H	20a. Method of Disposition 1 ☐ Burial 2 ☐ € remation 3 ☐ Removal from State  20b. Place of Disposition cernetery, critical state cernetery, critical states and the state of	ie, Md. 20721 osition (Name of ematory or other place)	Date 20c. L	ocation - City or Town, State					
<u>Ĕ</u>	Pag ment ant: I ury o			7 - 7 - 1	1/13/07 F	Riverdale, M	d.				
ä	ermit. epart poort ny inj		21. Signe ture of Funeral Service Licensee			Edwards F.H.					
_	ĕ.o. <b>≡ ≅.o</b> .		Junice Courances	910 Silver Hil	l Rd., Sui	tland, Md.20	746				
tý.			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	c or respiratory arrest,	Approxima Interval Be	ate etween				
	Physician	Ì	Immediate Cause (Final disease or conditiona. Urosepsis			Onset and	Death				
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			Days					
S	Examine:	_	Sequentially list conditions, if any, leading to immediate b. Acute Renal Fa	ilure		Days					
7	ted nsit	Examiner	cause. Enter Underlying	L							
- <u>-</u> -	execu al-tra	xar	Lause (Disease or Injury that initiated events resulting in death) Last  C. Diabetes Melli  Due to (or as a consequence of):	Lus		Days					
68760,	ficate be executed physician and is the burial-transit										
89	ificate g phy as the	edical	O								
Box	leath certif attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery	=1				
m.	death e atte	icia	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)			Year				
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ord	w require been slig should b	pe	Hypertension, Dementia, Depres	sion	1 ☐ Yes 2	□ No 3 □ Probably 4 🔀	Unknown				
မင္ပ	law r as be 2 sh	Completed	Sacral Decubitis		24a. Was an	24b. Were autopsy findings	available				
<u>~</u>		Ö			autopsy performed? 1∐ Yes 2∑ No	prior to completion of o death? 1 ☐ Yes 2 🎛 No	cause of				
Vital Records,	ician: Th certificate rector, pag		25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)						
	S 0 = 1	ု ရ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3□ DOA Other: 4□ Nursing H	ome 5 Residence	6 ☐Other (Specify)					
n n	ding F. h. After funera	ë	27. Manner of Death  1 XNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) Injury	f 28c. Injury at Work?	28d. Describe how injur	y occurred					
SIC	Attend death octor; /	cati	2 Accident investigation 3 Suicide 6 Could not be 280 Bloom of injury. At home forms of	M 1 □ Yes 2 □ No							
Division or	after death	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Num )	nber,				
			29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th cooursed at the time, date and also							
	e Hos 24 h e Fur etely	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date and	and manner as stated.  I place, and due to the cause(:	s)				
	ro th		29b. Signature and title of certifier	29c. License number	29d. Dat	te signed (Month, Day, Year)					
	- > - 0		· Anwedroften, M. i)	D0057630		uary 8, 2007	,				
	3	+	30. Name and address of person who completed cause of death (Item 23a) (Type,		vaii	ZGIY 0, 2007					
	1		7 71	gia Ave. #209,	Cilma- C	andne Ma occ	0.0				
	Stat		31. Date filed (Mogth, Day, Year) 32. Registrar's Signature	y±a AVE. #409,	SILVER S	11.1ng, Ma. 209	.02				
	Registra	r	SPAN D ZUU/ Kanan A A Santa	MEA IF							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day Year

January 10,2007 6:00P **Physician** White Jr. Edward Ernest /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1**⊋**M 2□F 65 Yrs. Dec.22,1941 Director 223-54-1751 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **ehow** rthen "naturel", or Iteme 23a or 28a-f ehov the Madical Examinar must be notified at 1⊠Yes 2□No **Funeral Director** Temple Hills PG 10g. Citizen of What Country? 10e. Street and Number United States 20748 6011 Southgate Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 TYes 2 No If Yes, Give within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dept. of Defense Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) if Item 27 is marked or other treumatic ev Lucille T. White Ernest E. White Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) hter 607 Mattawoman Way Accokee, Md. 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) Ouandetta Robinson/daughter 20c. Location - City or Town, State 20a. Method of Disposition ō 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important; If any injury or once. Lincoln Mem. Park 1/17/07 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sanature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final ASPIRATION PHE UMUNIP **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner GASTRU INTESTINAL WALLIAE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 1 IT I SHR B A or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,化 Due to (or as a consequence of): Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year After this certificate has been signed by the ette funeral director, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ KIEPIZT 1 Yes 2 No 3 Probably 4 Unknown EPILLURE CUNCESTIER Be Completed INTUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 5-6-6= 24a. Was an C YIRGHIC autopsy performed Cossured D& 1687 SCA BILL 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1' Natural 2 Accident 1 ☐ Yes 2 ☐ No s after death. 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by th 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1110/2007 019971 molden 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TALCOMA PARK MD 20912 CARTOLL XVE = 230. K. SUPHAKAR. MP 7660 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 18 A STATE OF THE PARTY OF THE PAR Registrar

State of Maryland / Department of Health and Mental Hygiene

		Certificate	of Death		g. No. 0 0 7	01031					
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		St. Vincent Care Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	Emmitsl		Frederi						
	Funeral Director		Days Hours Min.	8. Date of Birth (Month, Dey, July 23,		thplace (State or Foreign outling)					
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	or 28	10e. Street end Number 10f. Zip	Code	10	g. Citizen of What Co	ountry?					
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	1	30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)									
	\ 	ALAN CARROLL, M.D., 210 S. SETON AVE. EN  31. Date filed (Magnit, Day, Year), 2007 \$2. Registrer's Signature	MITSBURG, MI	21727							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** :18 Adams 2007 Wesley Jan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 213-30-9917 1 M 2 ☐ F Yrs. 15.193 Director Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 29a or 28a-f show important: If item Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director MaBaltimore Luthurville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Seminary 21093 617 W USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warerlu 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be intentional to the page of Health and Mental H Adams Mabel Adams alvin 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughte 4715 Norwood Ave Battimore Md 21207 li ane 20b. Place of Disposition (Name of \_\_cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FuneralHome heisterstown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myelon multiple /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and burial-trag Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 № No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L To the Hospital to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 9 2007

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month -09 5,2007 Januar Joro thi toams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Greneral Hospital
5. Social Security Number 6. Sex 17. Aga 1/10 mg Balfimure C7
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 M 2 M Hours Yrs. Director 219-20-5391 1922 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Modical Examinary sust be notified at 10d. Inside City Limits 1 498 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Preston St 624 21913 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Yes Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Dwidowed 4 □ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Head 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Heelth and Mental 2 Honre 19a. Informant's ame/Relationship (Ty = F int) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 91913 20b. Place of Disposition (Name of cometery, crematory or other place) Baltimore owenobly 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ŏ permit. Page Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 93 -07 21. Signatur Fun ral Service Licensee. 22. Name and Address of Facility aroline 21213 sucia 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Que to (or as a consequence of) Examiner sective Pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐ Pregnant at time of death P.O. | 9☐ Unknown 9 Unknown certificete has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Completed 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) Hospital or Attending Pl
 A hours after death.
 Funeral Director: After the 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) GOROTOW, MD. 40

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2007

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 9, 2007 **Physician** 4:00 AM M Evgeniya Ageyeva /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sykesville Carrol1 Continium Care | If Under 1 Year | II Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar 20, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🂢 F 74 Yrs. Director 066-80-5340 1932 Russia Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23a or 28e-f ehow the Medical Examiner must be notified at MD 1 ☐ Yes 2√ No Director Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 Second Avenue 21784 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify.white δ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk permit. Pages 1 and 2 should be flie Department of Heelth and Mental Hy Importent: If Nem 27 is marked othe eny injury or other traumetic event 90cg. 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Jones/Bureau of Aging 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 🛛 Other (Specify) in \$tate 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade Baltimore, MD Approximate Interval Between nset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. Il yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 22 No been sig 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2/2 No or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No မှ 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this After thi 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital within 24 hours a To the Funerel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the de cai 29a. Certifier and manner stated. Med 29b. Signature analytitle of certifie 29c. License number 29d. Data/signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person oner 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

**JAN 19** 

2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU/ Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 38A M 12,2007 Trace Januari /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Battimore 5. Social Security Number lowser If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Year) 1680 1 □ M 2 F 1936 Maryland Director ) core Usual Residence of Decedent 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No by Funeral Director Windsor Mill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3506 Hillsmere Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M once. ear Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pinkney (liford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MO 21239 Beverly F. Buster 20a. Method of Disposition 3 Mariora Rd Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore 4 Donation 5 □ Other (Specify) e <u>Mational</u> 31:17:2004 22. Name and Address of Facility Voughon C 172000 Green funcial Service 21. Signature of Funeral Service Licensee Vaugh C 729 Liberty Rd Kandall Stein 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kabenc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any course to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 2 DNo Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 ☐ Yes 2 🔀 No Medical Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after dea h. I irector: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

To the Hospital of within 24 hours of To the Funeral D

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) MANUN w

and manner stated.

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifie

32. Registrar's Signature

Registrar

SH

Mulline mo 21204

Registrar
DHMH 17 Rev 1/2001

State

M Schröde

JAN 1 9 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Mp 7500 Greenway Ctr Dr. Greenbelt, MD

		,	1 - For State Registrar	State of Marylar		artment of I ertificate of			ene () () 7	01038
	Physici		1. Decedent's Name (First, Middle, Last)  MYRTLE NANCY	Z BLACKBURN				2. Date of Death January	14,200 Ž <sup>ear</sup>	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give s Morningside Hou				or Location of Death	•	4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 237–10–1529 1□	M 2  F  7. Age (in yrs. 96	last birthday Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 1	9. Birt 1910 NO.	hplace (State or Foreign unin) rth Carolina
	D	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltin		ty, Town or L	ocation arkville				10d. Inside City Limits 1 ☐ Yes 2X No
	3s or 28	I Direc	10e. Street and Number 3005 Summitt Aven	ue		10f. Zip Code	21234	10	g. Citizen of What Co USA	
020	be filed within 72 hours after deeth with the Marylan Ital Hyglene. Id other than Instural, or Itema 23s or 28s-f show event, the Madical Examinat must be notified at	I by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
7-61717	i within 72 hours after iene. rthan "naturai", or Ite tha Medical Examina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	edent's Usual Occu e kind of work done DO NOT use retire il Clerk	pation during most of work ed)	king	6b. Kind of Business/ Hutzlers	Industry
and	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last)	7 0				e (First, Middle, M.	•	
2	should nd Men	ပ္	William Samue		19h Mail	ing Address (Stree		ie Elizab	Deth Call City or Town, State, 2	7in Codel
Z	nd 2 s eith an 27 is i		Betty Jo Boccuti-d	•					Taryland 2	
sammore,	permit. Pages 1 and 2 should I Department of Heelth and Men Important: If Item 27 is marka any Injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	EVa	ns Fur Tremat	osition (Name of ematory or other pla neral Cha ion-Bel A	pel Jan	18,2007		ll,Maryland
מ	Depar Impor any In		21. Signature of Funeral Service License	15-Judd		2. Name and Addr VANS FIN AND CREMA	DESCRIPTION OF THE PARTY OF THE	$_{ m FLS}^{ m EI}$ 8800	Harford I kville,MD	Road 21234
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consect	th. Do not er			or respiratory arres	st,	Approximate Interval Between Onset and Death
× '00	ifficate be executed g physicien and as the burial-transit	i Examiner	Sequentially list conditions, I any, seading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Descenha  Due to (or as a consecutive to (or as a consecutive to c						years
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.O. DOX	death cer e attendir d for use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of pregn 1 Live birth 2 Feti 4 Pregnant at time of o	al death 3	□Ectopic pregnand □ Other (specify)	ey		23d. Date of deli Month	ivery Day Year
cords, r	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	ed by Pt	Part II. Other significant conditions con	tributing to death but not re-	sulting in the	underlying cause gi	ven in Part I.		acco use contribute to	the cause of death?
al necc	i: The law ricate has be r, page 2 shi		14 TM Ily 10 My woin					24a. Was an autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of
N I G	s certification	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1  Inpatient 2	FR/Outpatie	ent 3 DOA Ot		th Check only one	ce 6 Other (Spec	passis free
DIVISION OF	ending Phy sath. or: After this he funeral c	ertification: T	27. Manner of Death 1 Naturaf 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju		28d. Describe how		ידינטון יועוני
Š	s after de s after de si Diracte sed in by t	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, s fy)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	e Hospit 24 hour e Funere	ledical (	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examinand manner stated.	owledge, dea ation and/or i	th occurred at the threating at the thre	ime, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier			29c. Licen	se number	290	d. Date signed (Monti	
	10		30. Name and address of person who co.	mpleted cause of death (fte	m 23a) (Type	D 37			1/15/07	
	,	**	31. Date filed (Month, Day Year)	O 9701 N	cha-C	w - 5.	The 7262	70wsa	mo 21	204
		State 31. Date filed (Month, Day, Year)  State JAN 1 9 2007  State 31. Date filed (Month, Day, Year)								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January Day 2,2007 **Physician** M. BENVENUTI JULIUS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre de Grace Harford Harford Memorial Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth Sept. 7, 1920 Birthplace (State or Foreign Country) 6. Sex 1X M 2 ☐ F **Funeral** 213-18-2014 Yrs. Italy Director Usual Residence of Decedent 10d Inside City Limits 10a State 10b. Count 10c. City. Town or Location 28e-f show the Medical Examiner must be notified at Abinadon 1 ☐ Yes 2 XNo MD Harford Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21009 522 Nanticoke Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: ð 3 XWidowed 4 ☐ Divorced 'naturai' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of permit. Pages 1 end 2 should be Department of Health and Mental Important: If Item 27 is marked 1 any injury or other traumatic evone. Salvatore Rocco Benvenuti Maria Costa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine B. Licata-daughter 522 Nanticoke Court-Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Redeemer

Holy Remetery Jan.16 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FINE AND CREMATION 8800 Harford Road Parkville, MD 21234 SERVICES Fudal 23a. Part1. Enter the disease, or complications that caused the death. Do-not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any lacon, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Hinkhown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. м 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signal re and title of certifier Doo 62903 ass of person who completed cause of death (Item 23a) (Type, Print) Harre De Grave MD 21078 Sunion MD 319 AVC 2. Registrar's Signature 31. Date filed (Month, Day, Year) State park 9 Registrar

BENVENUTI

			1 - For State Registrer	State of M	aryland / D		t of Hea	alth and M	1ental Hy	giene 0 0 7	01040					
	Physic	an	1. Decedent's Name (First, Middle, L		DIIO	FIA			2. Date of De Month	aath Day Yea	3. Time of Death					
	/Medi				BUB				JAN	15 200	- 7 00 01					
1	Examir	ner	4a. Facility Name (If not institution, grant LEVINDALE HE CENTER AND 5. Social Security Number 6.	HOSPITAL		DIIL	TIMO	RE, M								
	Funeral Director			Sex 7. Ag 1 ☐ M 2 📉 F	ge (In yrs. last birti 95 \	rs. Months		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da	9.8 5, 1911	Birthplace (State or Foreign Country)  New York					
			113-18-2310 Usuel Residence of Decedent						July 2	J, 1911	New TOLK					
	show		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits					
	Ba-f s	cto	Maryland		Balti	imore					1 Yes 2 No					
	ath with the Maryland \$ 23s or 28s-f show ust be retilied at	D Le	10e. Street and Number			10f. Zip		7		10g. Citizen of What	•					
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40	iter d	Funeral Director	11. Marital Status  ¹¾ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 □ Yes 24	'			nic Origin? (Sp lexican, Puerto	ecity Yes or No Rican, etc.)	Black, W						
036	urs aff	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	No S	pecify:		Specify:	White					
21215-0036	72 hours after death "natural", or items 23	Completed	15. Decedent's 8 (Specify only highest g	Education	16a.	Decedent's Usua	I Occupation	n most of work	ina	16b. Kind of Busine	ss/Industry					
2	c •	Jp.	Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of wo. life. DO NOT us		y most or work	iriy							
	be filed withintal Hygiene. Id other than	ပိ	12 17. Father's Name (First, Middle, Las	el .		Estima		Market A. Mark		L	g Company					
and	of the f	Be c	Roman Bubela	·()				Mary Be		, Maiden Sumame)						
Maryland	2 should be and Mental is marked of raumatic ever	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address				er, City or Town, State	Zin Code)					
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic. <u>once.</u>		Sophie Sleezer	Sist	er 32	215 Brig	htwood	l Ave.,	Baltim	ore, Maryl	and 21207					
Baltimore,	of He		20a. Method of Disposition		20b. Place of cemeters	Disposition (Nan , crematory or o	ne of ther place)	1 0	Date	20c. Location - City	or Town, State					
Ĕ	Page ant: if ury o		1 ☐ Burial 2X☐ Cremation 3   1 4 ☐ Donation 5 ☐ Other (Spec		1	Cremat	ory		7/2007		ore, Maryland					
alt	permit. Departr Importu any inju		21. Signature of Funeral Service Lice	ensee		22. Name an	d Address of	Facility St	erling	Ashton Sch	wab Witzke MD 21228					
_	88 58		Heller		-	1630 E	dmonds	son Aver	nue, Ca	tońsville,	MD 21228					
			SHOCK, OF HEART FAILURE, LIST ONLY	Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	Pnysician /Medical	1	disease or condition resulting in death)	a	SEPS13						Onset and Death  3 WEEKS					
	Examiner				a consequence of	•	-1110		0 = 10 1 1 ==	WE CHARM	2 1661/					
1		ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	VITH 1912 f):	FIHIC	ILLIN :	SENSII	AUREUS	2 WEEKS					
	ansit of	Examiner	that initiated exemts	FAILU		THRIN				, ,	4 WEEKS					
0,	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of	f):										
68760,	ificate be executed g physician and as the burial-transit	dlcai		d												
9 X	law requires that the death certificate as been signed by the attending phys. 2 should be defached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy						1					
Вох	atten atten for u	clan	23b. Was decedent pregnant in the past 12 months? 1 \(\simega\) Yes 2 \(\overline{D}\)No		2 Fetal death	3 ☐ Ectopic pro				23d. Date of d Month	lelivery Day Year					
P.O.	the d	nysi	1 ☐ Yes 2 ZNNo 9 ☐ Unknown	9□ Unknown		o 🖂 Otalor (spa	scny/									
	s that med t		Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying ca	use given in	Part I.	23e. Did to	obacco use contribute	to the cause of death?					
Records,	w require been sig should b	Completed by	END STALLE DE	MENTIA, I	YSPHAL	1A POS	T POI	10 -	101	res 2 <b>)</b> 7No 3□	Probably 4 Unknown					
ecc	law ri as be	plei	SYNDROME, AMB	MLATORY	DYSFUN	eTION,	62AST	RO-	24a. Was		autopsy findings available o completion of cause of					
<u>=</u>	ding Physician: The law n. After this certificate has t funeral director, page 2 s	Con	ESOPHALEAL						perfo	rmed? death' 2 X No 1 ☐ Ye	?					
Vital	Physician: r this certifica ral director,	Be	25. Was case referred to medical examiner?	Hospital:			011	Place of Death								
of	Phy	. To	1 Tes 2 No 27. Manner of Death	I □ Inpatie	ont 2 ☐ ER/Outp		A Other: 4			tence 6 Other (Sp.	pecify)					
on	th. th. : Afte	tlor	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju. (Month, Day	Year) Inj	ury M	Work? 1 ☐ Yes		ou. Doscribe i	iow injury occurred						
Division	Atter or dea octor by the	Iffice	3 Suicide 6 Could not to	286. Place of Inju	ury - At home, farr	n, street, factory	office		28f. Location (S	Street and Number or I	Rural Route Number,					
Ö	tal or	Certification;	4 - Homicide	building, etc	с. (Ѕресіту)				City or Tox	vn, State)						
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier (Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination and	death occurred a for investigation,	it the time, da	ate and place, and place, and place, and place and place and place and place and place are also and place and place are also are al	and due to the o	cause(s) and manner date and place, and di	as stated. ue to the cause(s)					
	To t To t	Σ	29b. Signature and title of certifier	MD			License nun			29d. Date signed (Moi	* * * * * * * * * * * * * * * * * * * *					
•	2		> Organ			D	005	3928	C	JAN. 18,	2001					
	4		30. Name and address of person who 2 4 3 4 W   BEI	completed cause of d	eath (Item 23a) (T	ype, Print) 5	URALY	A BE	GUM,	MD						
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	ML, 131	HLT11	TURE	IUD -	21215						
	Registr		-IAN 1 9 2	107 Estad	ar's Signature	parks ?										

			1 - For Stata Registrar	State of M		d / Depa	artment of rtificate of	Health	and M	ental Hyg		007	01041
		-	Decedent's Name (First, Middle, La	ist)						2. Date of Dea			3. Time of Death
П	Physici		Fred Leroy Barge							Month January	Day y 14	, 2007	11:00 PM M
	/Medio Examir		4a. Facility Name (If not institution, given Joseph Richey Ho.				4b. City, Town		n of Death			County of Dea	th
	Funeral Director			Sex 7. Ag	ge (In yrs. 60	last birthday) Yrs.	If Under 1 Yea Months Day		er 24 Hrs. Min.	8. Date of Birth (Month, Day 02/07/	194	9. 8in Cc PA	thplace (State or Foreign buntry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Mary	ō	MD Harford	i	Edd	rewood							1 ☐ Yes 2 No
	28a	Je C	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Co	ountry?
	3a o	<u>=</u>	1804 Harbinger Tr	rail			21040				USA		
9	should be filed within 72 hours after death with the Maryland Ind Menial Hygiene. marked other than "natural", or liems 23a or 28a-f show imatic event, the Madical Examinal must be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces 1  Yes 2 1 If Yes, Give	,		Was Decedent of If Yes, specify Cu 1 ☐ Yes 202 N			cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	e, etc.
ဗ္ဗ	ural',	d by	3 Widowed 4 Divorced	Year or Dates:			10103 2001	o opecii	···			Specify: Whi	te
1215-(	vithin 72 h ne. han "natu e Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e durina m	ost of workir	ng		nd of Business l <b>Estat</b>	,
Maryland 21215-0036	be filed stal Hygi od other event, I	Be	10 17. Father's Name (First, Middle, Last Harold Barge	)		nanu	/ MCAII			(First, Middle,	Maiden	Sumame)	
Mary	0 0 0	오	19a. Informant's Name/Relationship ( Barbara Barge/Wife				ng Address (Stre				-		Zip Code)
Baltimore,	ages 1 and 2 ent of Health ht: If Item 27 i y or other tre		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special		i	Place of Dispo emetery, crer	sition (Name of matory or other p ke Crema	iace)	D	ate Jan 18	20c. Lo	cation - City or	Town, State  Maryland
Baitii	permit. Pages to Depertment of Himportant: If Ite any injury or ot once.		21. Signature of Funeral Service Lice	· · · · · · · · · · · · · · · · · · ·	Mail	1117	Name and Add	ress of Fac	lity uneral	Alterna	ativ	es more. Ma	ryland 21286-
Ĭ	Physician	9 0	23a. Part 1. Enter the disease, or comshock, or heart failure. List only			h. Do not ent						•	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as		uence of):	- m	60	one	λ			Veas
/60,	eath certificate be executed attending physicien and for use as the buriat-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseq		• • • • • • • • • • • • • • • • • • • •	7					
9				u									
O. Box	O O	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	Ideath 3□	Ectopic pregnan Other (specify)	ncy			2	23d. Date of del Month	ivery Day Year
ds, P.O	as the	d by Ph	Part II. Other significant conditions of	contributing to death b	out not res	ulting in the u	nderlying cause o	given in Par	t I.	23e. Did to			the cause of death?
Records,	nystcian: The law require is certificete has been si i director, page 2 should t	omplete								24a. Was a autops perform	sy med?/	death?	Itopsy findings available completion of cause of
Vital		0	25. Was case referred to medical					26. Pla	ce of Death	1 Yes		TUTES	2□ No
	Physici this cer al direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1  Inpatio	ent 2	ER/Outpatien	it 3 DOA	thor				ther (Spe	phelita in
Division of	ling PI		27. Mano r of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da n	ry Ye <i>ar)</i>	28b. Time of Injury	W		2	8d. Describe h			, , , , , ,
DIVIS	는 HE E	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At ho c. (Specif	ome, farm, str	eet, factory, office	θ	2	8f. Location (S. City or Town	treet and n, State,	d Number or Ru	ural Route Number,
	To the Hospitel or within 24 hours efter within 24 hours efter To the Funeral Dir. completely filled in I	Medical	29a. Certifier 1 entifying Pt (Check only one) 2 Medical Example 1	nysician: To the best miner: On the basis of and manner st	t examina	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date a opinion, de	and place, a eath occurre	nd due to the c d at the time, d	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier					nse numbe		2	9d. Date	e signed (Monti	h, Day, Year)
	9		Kachel	5			DO	05	16		Ja	nuany	15,200+
	3		30. Name and address of person who Rache Ceune	BZNR	ma		Print) 1940 E	estr	- Ave	2. B.1	7.~	ne nu	15,2007 D 21224
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 9 200	7 Pegistr	ar's Signa	ture	Men 3						

# DOROTHY BULKNAM Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		Pie	ase Type or State			epartment of			•	ie.	
	•	For State Registrar	o ta to	oa. y .a.		Certificate of			Reg. No.	7 01	01.2
4	15	Decedent's Name (First, Mide	dle, Last)					2. Date of Dea	nth -	3. Time	of Death
Physicia /Medica		Dorothy Beckh	am					Tanual		Year 43	0 ам
Examine	_	4a. Facility Name (If not instituti		umber)	. /	4b, City, Town,	or Location of De		4c. County o	Death	
4.1		Maryland	STENERAL	- XIOSA	rital	Baltin	nore	City			
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs		Months   Day		lrs. 8. Date of Birtl in. (Month, Day Apr 15	r, Year)	9. Birthplace <i>(Stat</i> Country) South Car	
Director	ŀ	214-22-6605 Usual Residence of Decedent						Apr 13,	, 1910	outh car	ULINA
nyland how at	, [	10a. State 10b. Coun	у	10c. C	ity, Town o	or Location					City Limits
e Ma Sa-f s	ē	MD			Balı	timore				Λ	es 2□No
with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number	_			10f. Zip Code			10g. Citizen of Wh	nat Country?	
s 23a	Funeral	1000 N. Gilmon		ecedent Ever in	II S	13 Was Decedent of	21217		USA 14. Bace	- American Indian,	
ter de iner r	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed arried 1 ☐ Yes	Forces? s 2 📉 No	0.3.	13. Was Decedent of If Yes, specify Cu		ierto Rican, etc.)		White, etc.	
urs al	2	3 Widowed 4 Divorce	If Yes, t	Give T		1 ☐ Yes 2 💢 N	o Specify:		Specify:	white	
72 ho natur dical	eted	15. Decede (Specify only high	ent's Education lest grade complete	d)	1 (	ecedent's Usual Occ Give kind of work don	e during most of v		16b. Kind of Bus	iness/Industry	unk
/ithin ne. han " e Mec	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	7	ife. DO NOT use reti	red)				
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ပ္ပ	unk 17. Father's Name ( <i>First, Middl</i>	unk e. Last)				18. Mother's N	Name (First, Middle,	Maiden Surname	)	
d be featal	o Be	Emanuel M					Liz	zzie McNea	a1		
shoul ind M i marl	2	19a. Informant's Name/Relation	nship (Type. Print)			Mailing Address (Stre					
and 2 alth a 27 is		Maryland Gene	ral Hospi	tal	8	27 Linden	Avenue I	Baltimore,	, MD 2120	)2	
es 1 s of He f Item r oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 □ Bomoval fro		Place of C cemetery,	Disposition (Name of crematory or other p	lace)	Date	20c. Location - C	ity or Town, State	
Pag ment ant: I ury o	-	4 Donation 5 ☐ Other	(Specify)	J. State							
permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must boose.		21. Signatur - unera Service Remald	S. Wade	Birecto	or_	State Ana	ress of Facility Lomy Boa	rd 655 W.	Baltimo	re Stree	t
0 0 = 0 0		200 Port Fotor the disease	1/1/1	t coursed the de	oth Do no	Baltimore	MD 21	201	roet	Approxim	nate
ap .		23a. Part1. Enter the disease, shock, or heart failure. L. Immediate C. se (Final	st only one cause of	each line.	au. 50110		of Fa	T/URE	1631,	Approxin Interval I Onset ar	Between nd Death
Physician / /Medical		disease or con ition resulting in death)	a	to (or a conse	77 VC	e Hear	1 / 4	1700nC			
Examiner				o (or assections	squenoe or	,.					
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a conse	equence of	).					_
ecuted and I-transit	xaminer	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С								
2. □ 6	ωį	resulting in death) Last	Due	o (or as a conse	equence of	):					
ficate be ex physician as the burial	dica		d								
ding page as	Physician/Medical	IF FEMALE:	23c. If ves.	outcome pf preg	inancy				23d Date	of delivery	
atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Liv	e birth 2  Fe	etal death	3 ☐ Ectopic pregnate 5 ☐ Other (specify)			Mon Mon		Year
the d by the	nysi	9 ☐ Unknown	9□Un	known							
s that med b	Z P	Part II. Other significant cond	itions contributing to	death but not re	esulting in t	the underlying cause	given in Part I.	23e. Did to	bacco use contril	oute to the cause	of death?
equire en sig ould b	Completed by	bilateral	Preux	ac E	Ttu	5100		_   1 🗆 \	/es 2□No :	Probably 4	Unknown
law re as be 2 sho	plet							24a. Was	an 24b. W	ere autopsy findin	gs available of cause of
The ate h	E OE							perfo 1□ Yes	rmed2/   de	eath? □Yes 2□No	
cian; sertific setor,	Be (	25. Was case referred to medi examiner?	Hospital:			Ī		Death (Check only o	ne)		
Physi this c	ဥ	1 Yes 2 No 27. Manner of Death	1 1	☑Inpatient 2  te of Injury	ER/Outp			g Home 5 Resid	tence 6 Othe	11 2/	
ding h. After funer	ion	1 Natural 5 Pen		onth, Day Year)			ijury at /ork? □ Yes 2 □ No	Edd. Bescribe	ion injury docume	u .	
Atten deatl octor:	fical	3 Suicide 6 Cou	d and ha	ace of injury - At	home, farr	n, street, factory, office	ce	28f. Location (S	Street and Numbe	r or Rural Route N	lumber,
al or a after al Dire	Certification:	4 ☐ Homicide dete	bu	ilaing, etc. (Spe	сіту)			City or Tov	vn, State)		
ospit: hours unera ly fille	<u>رم</u>					death occurred at the /or investigation, in m					se(s)
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	ledical	one)	and m	anner stated.	nauon anu						
To To	≥	29b. Signature and title of cert	d A has		1-		ense number			(Month, Day, Yea	

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

			1 - For State Registrar		State	oi Maryla				lealth and Death	Wentai n	Reg. No		01043
	Bhusta		Decedent's Nam		Last)						2. Date of D Month	eath Da	y Yeer	3. Time of Death
	Physici /Medi		Donald								JAN	10		
	Examir	ier	4a. Fecility Name		give street and r	number)				STOWI			County of Deet	NGTON
	Francial.		5. Social Security	,	6. Sex	7. Age (In y	rs. last birthda	y) If Und	er 1 Year	If Under 24 Hr	s. 8. Date of E	linth		hplece (State or Foreign untry)
- 1	Funeral Director				1 <b>∑</b> M 2□F	66	Yrs.	Months	Days	Hours Mir	Mar 4	194 194		Laware
	pu »		Usuel Residence			100	City, Town or	Location						10d. Inside City Limits
	shov	5	10a. State MD	Washi	ngton	100.	Hager							1 ☐ Yes 2√ No
	n the Maryland r 28a-1 show	ecto	10e. Street and Nu				mager		ip Code			10g. Ci	itizen of What Co	puntry?
4	With Mith	ă		oxbury 1	Road					746			USA	
Dona L	after death with the Maryland or tems 23s or 28s-f show mer must be notified at	Completed by Funeral Director	11. Marital Status		12. Was De	ecedent Ever in Forces?	n U.S. 1	3. Was Dec		lispanic Origin? ( an, Mexican, Pue	Specify Yes or f	10-	14. Race - Ame Black, Whit	
3 0	after or its	F	_	rried 2 Marri	ed 1 ☐ Ye If Yes,	s 2 ∐MNo Give			2 <b>X</b> ) No		,		Specify: Wh	
	within 72 hours ene. than "natural", he Wedigal Exa	d b	3 Widowed	4 XDivorced	Year or	Dates:	160 Da	cedent's Us		nation	unk	16h k	Kind of Business	
15	n 72 n nat	lete			t grade complete		(Gi	ve kind of v	vork done	during most of w	orking	100.1	ting of business	moosily unk
121	with liene.	Eo	Elementary/Sec 8	condary (0-12)	College	(1-4or 5+)								
BGKER, DW Maryland 21215-0036	Il Hygie other	BeC	17. Father's Name	(First, Middle, I	ast)					18. Mother's Na	ame (First, Midd	le, Maidei	n Sumame)	
2 10	should be nd Mental marked c	10	Chester	Baker							ta Lowe			
C P	2 she and is my		19a. Informant's f							and Number or F				Zip Code)
			Merrill 20a. Method of Di	Baker/	brotner	20				s Road G	Date	_	DE 1994/ Location - City or	Town. State
altimore.			1 🗆 Burial 2	2 Cremation	3 Removal fro	m State	b. Place of Dis cemetery, c	rematory o	r other pla	ce)			,	
Ē	permit. Page Department Important: I any injury o				pecify) in s			22. Name	and Addre	ess of Facility ar	.1 CEE 11	Pal	ltimono	Ctwoot
Ba	permit. Departr importa any inj		21. Signature of F	Ronald S	Wade	WY ecc	or	tate Baltin	anat ore,	MD 212	01 033 W	, Da.	rtimore	Street
	198		23a. Peril. Enter	the disease, or	complications the	at caused the d	leath. Do not	enter the m	ode of dyi	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condit			ENA	LFI	41LU	12 E	_				Onset and Death
	/Medical		resulting in death	1)		to (or as a con								
	Examiner	L	Sequentially list of any, leading to	conditions,	b	MAB	STE	5						
	ed sit	lner	if any, leading to cause. Enter Und Cause (Disease of	immediate derlying or injury	Due	TO OF AS A CON		ARR	NTH	MA	5			
	cate be executed physician and the burial-transit	Examin	that initiated even resulting in death	nts	c. Due	to (or as a con	1		^ / / / )	1 ( - 1			1	
8760.	e be e	dical			d									
9	tificat ng phy as th	9												
Box	Attending Physician: The law requires that the death certificated with the death certificated.  Sector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decede		23c. If yes, 1⊟Liv	outcome of pre e birth 2 🔲 F		3 □Ectopic	pregnanc	у			23d. Date of de Month	livery Day Year
A 9	ne death the atte	sic	in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 □ No		egnant at time iknown	of death	5 🗌 Other (	(specify) _			-		<b>52,</b>
7	that the ded by the detached	Phy	Part II. Other sign		ns contributing to	death but not	resulting in the	underlying	cause o	ven in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
13 0	signed be del				3		,	, .			1(	Yes 2	2 No 35/P	robably 4 Unknown
to	w requir been si should	Completed									24a. W	as an	24b. Were at	utopsy findings available
A. Be	he law e has l	d mc									pe	topsy rlormed?	death?	utopsy findings available completion of cause of
) > =	ician: Th certificate rector, pag	a	25. Was case ref	erred to medical						26. Place of D	1 ☐ Yes		0 10 765	2000
5	ysicia is cer direct	To B	examiner? 15 Yes 2[	□ No	Hospital: 1	☐ Inpatient	2 ER/Outpa	tient 3	DOA O	her: 4 ☐ Nursing	Home 5□Re	sidence	6 Stother (Spe	INFIRMAR
74t	ding Phys		27. Manner of De	ath 5 🗆 Pendin	//	ite of Injury fonth, Day Yea	28b. Time Injur	У	28c. Inju		28d. Describ	e how inju	ury occurred	
Ö	death. ctor; A	catle	2 Accident		gation			М		]Yes 2 □No	OPE Leastine	/Ctrans	and Mirmhan or C	um l Coute Number
į	or Att	Certification:	4 Homicide	datarm	100d   200. Fk	ace of Injury - Auding, etc. (Sp	At home, farm, pecify)	street, fact	ory, office		City or	Town, Sta	te)	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier	1 Certifyin	o Physician: To	the best of my	knowledge, de	ath occurr	ed at the t	ime, date and pla	ce, and due to ti	ne cause(	s) and manner as	s stated.
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only one)	2 Medicat	Examiner: On the	e basis of exar	mination and/o	rinvestigati	on, in my	opinion, death oc	curred at the tim	e, date ar	nd place, and due	to the cause(s)
	To th within To th	Me	29b. Signature ar	nd title of certifie	Γ,			1	29c. Licen	se number	0.3	29d. D	ate signed (Mon	th, Day, Year)
			1 /2	Mal	71	M.T	)	(	0	0633	83	JA	+N 10	J007
			30 Name and ad	011		ause of death		pe, Print)		EFST	)			
			SAHIN		MALI	N Bacintord - 0	MCI	1 , 1-	AG	EKST	NW			
	St Regis	ate	31. Date filed (M	onth, Day, Year)		Registrar's S	H. A	made)	p					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #4a&b Per PHY G863 / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Charles L. Burchfield 6, 2007 8:54 AM /Medical January 4b. City, Town, or Location of **Bel Air** 4c. County of Death 4a. Facility Name ("Chiesapeake Medical Center Examiner 1518 Philadelphia Road <del>Joppa Road</del> Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠** M 2□ F 89 Jan 17, Director 1917 Tennessee 408-24-0221 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits f show filed within 72 hours after death with the Marylar Hygiene.

Other than "natural", or items 23a or 28a-f showent, the Medi-al Examiner must be notified at 1 ☐ Yes 2√∑ No Harford Director Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1518 Philadephia Road 21085 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) O auto mechanic automotive f Health and Mental Hygiv Item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fand Mental I Jessie Robert Burchfield Edith Hester ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Burchfield/son 1813 Barrington Village Court Bel Air, MD 21014 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Sign ture of Euneral Stryice Sicensee Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cao e (Final disease or condition resulting in death) aARTERIOSCLEROTIC CARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list and as or injury Lue to (or as a consequence of) that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 2∐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 6, 2007 jantar

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 9 2007

M. ASHYANVAR 2 WORTH KVE

Ionth, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

m80037406

Charles

Burchfield,

NUE

MD 21014

		1 - For State Registrar		Maryland		artment of <i>rtificate o</i>		d Mental Hy	/gienę Reg. Nd	2 [] []	7 0104
Physic		1. Decedent's Name (First, Middle HARRY	e, Last)			BAKE	D	2. Date of De Month	Day		A 4 A Pro- 1-1
/Med Exami		4a. Fecility Name (If not institution	n, give street and num	ber)			, or Location of D	January	-	County of De	
		Johns Hopkins B		incal Cer	nter		more				
Funeral Director		5. Social Security Number  220–18–8216  Usual Residence of Decedent	6. Sex 1  M 2 ☐ F	7. Age (In yrs. Ia 78	ast birthday, Yrs.	If Under 1 Year Months Day		din. 8. Date of Bi (Month, D Mar 24	rth a <i>y, Year)</i> 19	28	Birthplace (State or Fore Country) un
yland		10a. State 10b. County		10c. City	, Town or L	ocation					10d. Inside City Lim
e Mar	ctor	MD Balt	imore		Dunda	1k					1 ☐ Yes 2🛣 1
with the Maryland a or 28e-f show	Dire	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What	Country?
deeth with the Maryland ms 23a or 28e-f show Imast be notified at	Funeral Director	121 Kinship Ro	k 12. Was Deced	lent Ever in U.S	3 13		1222	(Specify Ves or N	o- T	US	SA nerican Indian.
<u>a</u> 2 2	þ	1 Never Married 2 Marr	Armed Fore	ces? u: 2 □ No u:	nk	f Yes, specify Cu 1 ☐ Yes 2 X N		(Specify Yes or No Jerto Rican, etc.)		Black, Wi	hite, etc.
within 72 sne.	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) unk	t grade completed)  College (1-	4or 5+)	(Give	dent's Usuat Occ kind of work don DO NOT use reti	a during most of	working unk	16b. Ki	nd of Busines	ss/Industry un
Viand Z buid be filed Mental Hygi arked other atic event, ii	To Be Co	17. Father's Name (First, Middle,	unk Last)			unk	18. Mother's f	Name (First, Middle	, Maiden	Sumame)	un
re, Marylan 1 end 2 should be 1 heelth and Mental 1tem 27 is marked other treumatic ev	-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Stre	at and Number or	Rural Route Numb	er, City or	r Town, State	. Zip Code)
C = W -		Hopkins Bayviev	Medical (		4940	Eastern		Baltimore			
Page:		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 ☒ Other (S)	3 □Removal from Si Decify) in sta	tate Ce	ace of Dispo metery, crei	sition (Name of natory or other p	lace)	Date	20c. Lo	cation - City o	or Town, State
permit. Departm importal eny inju		21. Signature of Funeral Service Anthony	Steas	ant	Ba	altimore	. MD 21	rd 655 W. 201		timore	Street
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car only one cause on ear	used the death. ch line.	Do not ent	er the mode of dy	ring, such as card	liac or respiratory a	rrest,		Approximate Interval Between
Pnysician /Medical		tmmediate Cause (Final disease or condition resulting in death)	-a Hy	per Co	arb	ia					Onset and Death  H days
ificate be executed XB physician and as the burnal-fransit and	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	uentially list conditions, y, leading to immediate se. Enter Underlying se (Disease or injury initiated events				Jmona	seas	c	25 year	
The law requires that the death certific file law requires that the death certific sie has been signed by the attending page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏Fetato nt at time of dea	death 3	Ectopic pregnan Other (specify)	су		2	3d. Date of do	elivery Day Year
Tures that n signed b	۾	Part II. Other significant condition	ns contributing to dea	th but not result	ting in the u	nderlying cause g	iven in Part I.	11	obacco us		to the cause of death?
VICAL THE LAW requires to signer certificate has been signer inector, page 2 should be on	Completed							24a. Was autor perio 1  Yes		prior to death?	autopsy findings available completion of cause of
sician: T certificate iractor, pa	o Be	25. Was case referred to medical examiner?	Hospitat:			10	ham	eath Check only o	ne		
ding Physin. The this funeral directions	H	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig.	28a. Date of (Month,		R/Outpatien 28b. Time of Injury	28c. Inju		Home 5 Resid			ecify)
To the Hospital or Attending Physician: within 24 hours alter death.  To the Funeral Director, After this certifical completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not determine	ot be 28e. Ptace of	tnjury - At hom , etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or F	lural Route Number,
he Hospit n 24 hours he Funere pletely fille	Medicai (	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the basi xaminer: On the basi and manne	s of examinatio	ledge, death on and/or inv	occurred at the t	ime, date and pla opinion, death oc	ce, and due to the c curred at the time, o	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
To t withi To ti comp	×	29b. Signature and title of certifier	Medi	001	10t- c		se number				th, Day, Year)
		30. Name and address of person w			23a) (Type, I	Print)	-000	7	anu	ary -	1,2007
				stem		ne B	altimor	re man	ylar	nd :	21224
Sta Registr		31. Date-filed (Month, Day, Year)		istrar's Signatu	re			•	J		

	D	irecto
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hvoiene.	Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at a contact to the traumatic or other traumatic at a contact to the traumatic or other traumatic event, the <u>Medical Examiner must be notified at a contact to the </u></u>
	Phy /M Exa	siciai edica mine
	nted	nsit

Funeral

To the Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra

Division or Vital Records, P.O. Box 68760,

	1- State Registrar Certificate of De	0.00 00 000 000 000
ian ical	I HETCONPHEN A DENVIN	2. Date of Death Month Day Year 3. Time of Death Average 8 2007 10:47
ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Death  4c. County of Death
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1	Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 19, 1960 Haryland  9. Birthplace (State or Fore Country) Maryland
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Lim
Director	MD Baltimore	1 <b>½</b> Yes 2□
al Dire	10e. Street and Number 1302 Kuper Place 2122	10g. Citizen of What Country? USA
To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year or Dates:	panic Ongin? (Specify Yes or No- Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: black
oleted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done dur. life. DO NOT use retired)	on $unk$ 16b. Kind of Business/Industry $unk$
Completed	Elementary/Secondary (0-12) College (1-4or 5+)	
To Be	17. Father's Name ( <i>First, Middle, Last</i> )	8. Mother's Name (First, Middle, Maiden Surname)
		d Number or Rural Route Number, City or Town, State, Zip Code)
1	Roxanne Murphy/friend 2536 Wilkens A	venue Baltimore, MD 21223
	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 🖫 Other (Specify) in state	Date 20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee Anthony B. Pleasant State Anatom Baltimore, M	my Board 655 W. Baltimore Street
sal Examiner		
Physician/Medical		23d. Date of delivery Month Day Year
þ	2 Control Significant containing to death but not resulting at the underlying cause given a	in Part I. 23e. Did tobacco use contribute to the cause of death?  1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Completed	Complete	24a. Was an autopsy performed? performed? 1 Yes 2 \overline{\infty} No 1 \overline{\text{yes}} 2 \overline{\text{No}} No
Be	Hospital'	6. Place of Death (Check only one)
Certification: To	Hampatient 2 EH/Outpatient 3 DOA	4 Nursing nome 5 Hesidence 6 LiOther (Specify)
		28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical		date and place, and due to the cause(s) and manner as stated.  ion, death occurred at the time, date and place, and due to the cause(s)
Σ	29b. Signature and title of certifier 29c. License nu	umber 29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1088   JAN 8, 2001
ate	ANDRE MOULEIDOUX 22 S. Creens  31. Date filed (Month, Day, Year) 32/Registrar's Signature	e St. Baltinore, MD 21201
rar	IN N. 1. U. 2007   Black P. March P.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #PII,25,27,28a-f, perVE, g863, Certificate of Death

Red. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 13, 1:30  $A^M$ S. January Elizabeth Buress 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** OakCrest Retirement Community Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F Yrs July 29, 1926 80 Maryland 213-32-2607 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8800 Walther Blvd. 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White If Yes, Give Year or Dates. \$ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Nurse 5+ Medical land; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fi th and Mental H 7 Is marked oth Be William Eyre Sisson, Sr. Mary W. Hairston ပ Itimore, Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Mary Katherine Koehler/Daughter 10316 Greenbriar Ct. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 15. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2007 4 □ Donation 5 □ Other (Specify) Catonsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DE0515 /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BYMPOUTH EXAMINER **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burlal-transit Due to (or as a consequence of) 68760, pe Physician/Medical Box IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9□Unknown Ö 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det Records, 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hip Fracture autopsy performed this certificate 1□ Yes División or Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 2 ER/Outpatient 3 DOA Certification: To funeral To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 📉 No Nov. 10, 2006 unk fall 2 X Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8800 Walther Blvd. 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide residence Parkville, MD 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard Parkville, alther Day, Year) 32. Registrar's Signature State Dade Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Month Jan. 17, Bernard James Burke 2007 11:35 AM 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 12246 Roundwood Road #106 Timonium Baltimore 8. Date of Birth (Month, Day, Year) FeD. 5, 1924 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 → M 2 → F 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Months Days Hours Min Mary Tand 212-07-6096 92 Yrs. Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12246 Roundwood Road #106 21093 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Spirits 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Burke Catherine Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Joanne P. Burke/Wife 12246 Roundwood Road #106 Timonium, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Dulaney Valley Mem. Grd. 1/20/07 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Pert1. Enter the diseese, or shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bronchiectasis with respiratory pulmonar obstructive Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): aspiration pneumonia Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of deeth? performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

been signed by the attanding physicien and should be detached for use as the burial-transit The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, cartificate has the director, page 2 s Attending Physician: To the Hospital or Attending Physic within 24 hours effer death.

To the Funeral Director: After this ca complataly filled in by the funeral dire

**Physician** 

Examiner

**Funeral** 

Director

ir than "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at

with the Merylend

Pages 1 end 2 should be filed within 72 hours after daath

oth and Mantal Hygie 27 Is marked other t r traumatic event, un

Depertment of Heelth a Important: If item 27 is any injury or other train once.

**Physician** /Medical

Examiner

Examine

Physician/Medical

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Completed

Be

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Certification:

Medical

Baltimore, Maryland 21215-0020

/Medical

Directo

Funeral

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Completed

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Menner of Death Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Un Wint

Win Myint

29c. License number D0055301

29d. Date signed (Month, Day, Year) 18/2007

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

1

6701 North Charles St. Suite 5100 Towson, MD 21204

State Registrar 31. Dete filed (Month, Day, Year)



			1 - For State Registrar	State of Ma	aryland		artment rtificate			nd Me	-	giene Reg. No:	007	1	1049
			1. Decedent's Name (First, Middle, La	st)		,				1	2. Date of De. Month	ath Day	Yee		3. Time of Death
н	Physici /Medio		JOHN G	BURFOR	ZD	JR.					lanuar	3 0	5 200	7/	7:54 PM
	Examin		4a. Fecility Name (If not institution, giv				4b. City,	Town, or	Location of	Death		4c.	County of D	eath	
			JOHNS HOPKINS BAY	VIEW MEDIC	AL CE	VIER	13	BAL	TIMO	RE				N,	/A
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. las	it birthday)	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. 8	B. Date of Bir (Month, Da	v. Year)		Birthplac Country	e (State or Foreign
	Director		213-36-4722	<b>X</b> M 2□ F 6	7	Yrs.					Aug 0	7,193	39 W		Virginia
	p ,		Usuel Residence of Decedent		10a City	Town or Lo	eation							104	. Inside City Limits
	aryla hov	<u>.</u>	10a. State 10b. County		Toc. City,	TOWN OF LO	Cation	T)	ndalk					100	1 ☐ Yes 2 No
	88-4	cto	2	imore					IIUalk			10 011	(144)		
	dh th	Director	10e. Street and Number				10f. Zip	Code				_	zen of What		
	ath v		7624 Parkwood						2122		7 77		ited S		
	er de	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Deced If Yes, spec	ent of His ify Cubar	spanic Origi n, Mexican,	Puerto R	ify Yes or No ican, etc.)	-	14. Race - A Black, W		
36	s aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 √ Yes 2 □ N If Yes, Give Year or Dates:	NO		1 ☐ Yes 2	No No	Specify:				Specify:	W	hite
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f ehow item "Modical Examiner must be notified at	D D	15. Decedent's Ed		-	16a Decer	dent's Usua	I Occupa	tion			16b Kir	nd of Busine		
5	n 72 n ne	Completed	(Specify only highest gra	ide completed)		(Give	kind of wor DO NOT us	k done d	uring most of	of working	7	702.74			,
12	with:	E C	Elementary/Secondary (0-12) 10 Years	College (1-4or 5	+)	I	nstal	lati	on			Carr	et Co	mpaı	ny
	Hygi Hygi other		17. Father's Name (First, Middle, Last,	)						's Name (	First, Middle,	Maiden	Sumame)		
an	d be ental	To Be	John Gus Burford	. Sr.					Ethe.	l Pet	tre				
Maryland	shoul mari	۲	19a. Informant's Name/Relationship (			19b. Mailir	ng Address	(Street a	nd Number	or Rural	Route Numbe	er, City or	Town, Stat	e, Zip Co	ode)
Š	tra		Mrs. Roberta L.	Burford(Wi	fe)	762	4 Par	kwoo	d Roa	d I	Dundal	k, Ma	arylar	nd 2	21222
	s 1 and 2 of Health a item 27 is		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Nam	ne of	1	Da	te	20c. Loc	cation - City	or Town	ı, State
10	y or		M⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				Cemet			1/19	/2007	Ва	ltimor	e, l	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinar must be notified at once.		21. Signature of Funeral Service Licer		Joan						ome of	Danne	3 - 11:	Tna	
B	Depa impo any ir		10.00	( a							dalk,			212:	
	-		23a. Part 1. Enter the disease, or com	plications that caused	the death.								Lana	A	pproximate
			shock, or heart failure. List only Immediate Cause (Final	۸		1			, ,					0	nterval Between
	Pnysician /Medical		disease or condition resulting in death)	a ACUT			ARL	2114	<u> </u>	SFA	RCTIO	10		30	minutes
П	Examiner			Cons	- /4/	· A	RTEI	0	Disa	CASE	=			5	years
	38	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	-	101	~/	0(30						gerer 3
8	uted	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events												
ř	exect	Exa	resulting in death) Last	Due to (or as	a conseque	nce of):									
68760,	ate be executed hysician end the burial-transit	cal	(	d											
89	ificat g phy as th														
Box	andin use	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pro	000000				2	3d. Date of	delivery	
m	death certifica e ettending ph id for use as t	Cla	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at			Other (spe	,					Month	Da	ay Year
P.O.	t the by th tache	Physician/Med	9 ☐ Unknown	9□ Unknown							7				
S, F	The law requires that the death certifica ete has been signed by the ettending ph page 2 should be detached for use as tt	<b>by</b> P	Part II. Other significant conditions of	contributing to death b	ut not result	ing in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco u	se contribute	e to the	cause of death?
ä	w require been sig should b	ed									10,	Yes 2	]No 3 ☐	Probab	ly 4 Onknown
CO	aw requ is been 2 should	plet									24a. Was		24b. Were	autopsy	y findings available letion of cause of
æ	The i	Completed									10 Yes	rmed?	death	1?	ZNo
ita	en: rtifice tor, p	8	25. Was case referred to medical						26. Place	of Death	Check only o				
2	ysici is ce direc	ToB	examiner? 1 Yes 2 No	Hospital: Inpatie	nt 2 🗆 EF	R/Outpatier	nt 3 DO	A Othe	4 Nurs	sing Hom	e 5 🗆 Resi	dence 6	Other (S	Specify)	
0	ig Ph ter th neral		27. Manner of Death  ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 2 y Year) 2	8b. Time of	f 2	8c. Injury Work	at ?	28	d. Describe I	how injury	occurred		
Ö	Attending ir death. ector: After by the funer	atlc	2 ☐ Accident investigatio	n			М		res 2□N	0					
<b>Division of Vital Record</b>	er de recto	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At hom	e, farm, str	eet, factory	, office		28	If Location (S City or To			Rural F	loute Number,
ā	taio rs aft ai Di	Cer													
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	cal	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the best of minar: On the basis of	of my knowl examinatio	edge, deat	h occurred a	at the tim	e, date and	place, an	nd due to the	cause(s)	and manner	as state	ed. le cause(s)
	the h the f	Medical	one)	and manner sta											
	To To Con	2	29b. Signature and title of certifier	1170	1			. License					signed (Mo		
•	- %		r (pull	" tale			/	CES	-00	0-0		JANU	ARY	15,	2007
	211		30. Name and address of person who	-		(Type,	Print)								2
	9.		0.40 00 10 10 1		1940	CA	STER	N A	VENU	E B	ALTIM	ORE	1111	1	41224
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar a arginatu	To Some	100								
	5,01		EBBIT U 7HH	1 428 30 166	9.0	A ST									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200<sup>Year</sup> Batoul Bahrami January 2:25 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town or Location of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 29, **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min 561-89-4943 85 Director Iran Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c, City, Town or Location 10b. County 10d. Inside City Limits Funeral Director Maryland Montgomery Potomac 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9912 Chapel Road 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by White 3 XWidowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) Ali Bahrami ပ Fatemeh Khandani 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moshen Bahrami/Son 13318 Queenstown Lane, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service Licer Robert A. Fundament Funeral Home, Bethesda-Chevy Chase, Inc. 23a. Part1. Enter the disease, or complications, at aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific and specific arrest arr 7557 Wisconsin Avenue, Bethesda, MD 20814 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Asystole /Medical Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 □Ectopic pregnancy 4☐Pregnant at time of death Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1□ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After t 28b Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 🗌 Yes within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature 29c. License number and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 7608 Killbarron Drive,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Sabharwal,

31. Date filed (Month, Day, Year)

D006447S

Laurel, MD

20707

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: filled in by within 2

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c, License number

29b. Signature and title of certifier

R25-000

29d. Date signed (Month, Day, Year)

January

12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, HD Dr. Jennifer Berhelev

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 19



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: -Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 15 2007 Physician CISIE 5:15a \*/Medical romani 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Director Md214-22-2473 Jan 27, 1924 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No r 28a-f sh notified Funeral Director onkton 4 Baltimore 10e. Street and Number 10g. Citizen of What Country? a or ms 23a USA 616 romwell "natural", or items dical Examiner mi 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: & Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Battimore Co. Public Schols 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental James Smith ၉ JOHNSON 1516 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Spe Jan of Health a WhyeLa 016 Lromwell Md 21111 lonkton permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-19-07 es Church Cem Hereford 22. Name and Address of Facility Chaman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reistestown Bd Baltimore avoy 23a. Part1. Enter the dil ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Small Immediate Cause (Final disease or condition resulting in death) World K metastatic 20 cancerc **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): burial-P.O. Box 68760 physician the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⋈ No autopsy performe page certificate 1☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 2 No ၉ 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: After or Attending (Month, Day Year) Injury **Division** 1 Natural 5 Pending after death.

I Director: After the full of the full o 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled it Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kichar (L, HUSIA 1505 OSULTDR, Sci17E 302 Toloson MD 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar	State of Maryland / I	Departmen		Mental Hygi	•	01053
	Physic	ian	1. Decedent's Name (First, Middle, Last)	C C OU'	コール		2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examii	cal	4a. Facility Name (If not institution, give sti Anne Arundel Medi	reet and number)	4b. City,	Town, or Location of Dea	ath	4c. County of Dea Anne Aru	th
1280	Funeral Director		5. Social Security Number 017–10–1733 6. Sex 150.  Usual Residence of Decedent	7. Age (In yrs. last bii 95	rthday) If Under Yrs. Months	1 Year   If Under 24 Hi Days   Hours   Mil		9. Bir Co	thplace (State or Foreign buntry) RI
	e Maryland	ctor	10a. State 10b. County MD Anne Arun	de1		Lothian			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	3a or 26	I Director	10e. Street and Number 118 Konrad Morg	an Way	10f. Zip	<sup>Code</sup> 20711	100	g. Citizen of What Co USA	
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 ie marked other then "naturel; or iteme 23a or 28e-f ehow other traumatic event, the Medical Eventral must be routified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2€ No If Yes, Give Year or Dates:		lent of Hispanic Origin? ( ofly Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	filed within 72 h Hygiene sther then "natu	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)			al Occupation ork done during most of w se retired) rinter	orking 16	6b. Kind of Business.  Newspa	
Maryland	ould be filed Mental Hygid Marked other Matic event, II	To Be C	17. Father's Name (First, Middle, Last) Albert Cloutier			18. Mother's Nari	ame (First, Middle, Ma e Anne H	aiden Sumame) Harpin	
	. I and 2 should Health and Men tem 27 le marke other traumatic		19a. Informant's Name/Relationship (Type Phyllis R. Gagne /		. Mailing Address 65 Round	(Street and Number or F	Rural Route Number, ( Harrisvill	City or Town, State, 2 .e, RI 018	₹ip Code) 30
Baltimore,	permit. Pages 1 a Department of He Important: If item eny injury or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 Rea 4 Donation 5 Other (Specify)	noval from State St. J.	f Disposition (Namery, crematory or of OSEPh 's	Cemetery 1/	Date 20 19/2007	Oc. Location - City or Webster,	
Balt	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Licensee	volall	Charle	d Address of Facility S L. Steven ast Fort Av	s Funeral enue, Balt	Home Inc.	21230
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. Do cause on each line.  Puer to (or as a consequence	zed 1	e of dying, such as cardia		t.	Approximate Interval Between Onset and Death
90,	acuted and transit	Examiner	frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence					
.O. Box 68760,	The law requires that the death certificate be ex Ite has been signed by the ettending physicien a tage 2 should be detached for use as the burial	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pre 5 □ Other (spe			23d. Date of del Month	ivery Day Year
rds, P	quires that n signed k ald be det	by	Part II. Other significant conditions control	buting to death but not resulting in	n the underlying ca	use given in Part I.		cco use contribute to	0
Vital Records,		Completed	Vonconzein	Resistant En	Nrococc	eus UTI	24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
	Physician: T this certificat al director, pa	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hos	spital: 12 Inp tient 2 ☐ ER/Ou		Other	ath Check only one		
ion of	ding After fune			28a. Date of Injury 28b. T		A 4 Nursing Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	Home 5 Residence 28d. Describe how		rfy)
Division	or in I	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory,	office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)	ian: To the best of my knowledge r: On the basis of examination and and manner stated.	, death occurred a d/or investigation,	at the time, date and place in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To T To t	Σ	29b. Signature and title of certifier	entaun		Cicense number	38	Date signed (Month	16,2007
	<b>b</b>		30. Name and address of person who open	NM an 44T	Type, Print) DeFENSE	HIGHWAY,	ANNAPOLI	SMO 21	40/
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Carles .				

07-00314 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Harvey Culp 1- For State Certificate of Death Reg No. Registrar 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Month Day January 11, 2007 Medical Examiner RURU 1628 hrs 4 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Date of Birth (MM/DD/YYY 9. Birthplace (State or **Funeral** Davs Hours Director 247-74-5 -5 95 1 M 2 Country) Usual Residence of Decedent 10a. State 10b. County Town or Location 10d Inside City Limits NIA 1 Yes 2 No or 28a-f show notified at once. irector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ä items 23a Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes 0. Widowed 4 Divorced If Yes. Give Year Yes 2 No specify injury or other traumatic event, the Medical Examiner "natural", þ 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene Important: If item 27 is marked other than " 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Kachel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Stere Balto. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 W Burial Cremation 3 Removal from State andacistum Donation 5 King mem. Other Specify 21. Sign , e of Fun ral Service license 22. Name and Address of Facility the disease, or or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, shock, or heart use on each line. Complications of head injuries art | E | r the dise e, or complications fail e. List only one cause on each line. Approximate Interval **Physician** /Medical iate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) d Physician/Medical UNPENDED physician perME IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic cardiovascular disease Completed 24a Was an autopsy performed? death? Yes 2 1 🗸 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient DOA 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes ۵ 28d. Describe how injury occurred Manner of Death 28b. Time of Injury 28c Injury at Work unk Medical Certification:

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

24b. Were autopsy findings available prior to completion of cause of No 28a. Date of Injury (Month, Day, Year) Unknown Natura 5 Pending Yes 2 V No Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State) unknown, unknown, MD determined (Specify) Major Road / Highway Homicide

29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License numbei

O.C.M.E

29d Date signed (Month, Day, Year) January 12, 2007

South

Death

Year

30 Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month Day, Year) State Registra

32. Redistrar's Signature

ORIGINAL

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Baltimore, Maryland 21215-0036 Box 68760,

The law requires that the death certificate be executed burial-tran as the attending p P.O. ed by the s been signed be should be deta Records, rector, page 2 s Division of Vital After this certific funeral director, Hospital or Attending death. n 24 hours after death.

The Funarel Director: A felely filled in by the fun

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 6:05 AMM Lester B. Colwell 2007 01 2 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KANASULA REGIONA Medical 54/15/04/4 Wicomico Centle If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 7, 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 69 California Director 566-42-4519 1937 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 show any injury or other treumatic event, the Modical Examinat must be notified at once. 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Times Square 21804 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: white Specify: 3 Widowed 4 □ Divorced 1955 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DD NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 civil engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Bruce Colwell Joyce Josephine Tell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford Colwell/son 4602 Ohear Avenue N. Charleston, SC 29405 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Leasant Statend Affatto Board 655 W. Baltimore Street 21201 mony Baltimore, MD 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSUS 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION PINEUMONIA 2-days Sequentially list conditions. Sequentially list conditions, if any, leading los immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (un as a consequence of) Examiner 5 44441 Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 des 2 de 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the sause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 ÷ ÷ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) role Neh DO 57359 30. Name and a mess of person who completed cause of death (Item 23a) (Type, Print) ST, SALISBURY DR-USIFA 1415 . S. DIVISION 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**JAN 1 9** 

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 ☑ No

Approximate Interval Between

Onset and Death

11:22 A.M

2007

Specify.

JANUARY 17, 2007

21014

HARFORD

White

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the To the Hospital or Attending Physician: within 24 hours after deal

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of	b. Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)		wlea						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic	pregnancy (specify)		23d. Date of de Month	olivery Day Year			
	ontributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobacc  1	2 No 3 P	to the cause of death?  Irobably 4 Unknown  utopsy findings available completion of cause of s 2 UNo			
25. Was case referred to medical examiner?		•							
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	Home 5 Residence	6 □Other (Spe	ecify)				
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	jury occurred				
3 Suicide 6 Could not be determined	e 28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory)	28f. Location (Street City or Town, Sta	and Number or R ate)	lural Route Number,				
27. Manner of Death  1 Natural 5 Pending  2 Accident  3 Suicide 6 Could not by determined  29a. Certifier (Check only one)  1 Certifying Phase one)	nysicien: To the best of my known inter: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)			
29h Signature and title of certifier	29c Licence gumber 19d Date signed (Month Day Very								

032255

BEL AIR, MD.

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daves 5 D.

DR. DAVID DUNN

		1 - State Registrer		land / Depa <i>Cei</i>	tificate of D	Death		g. No.	UIUD	
		Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Dea	
Physici /Medic		MARVIN E C	203014				Month	Day Yea		
Examir		4a. Facility Name (If not institution,			4b. City, Town, or L	Location of Death	1 8	4c. County of De		
		GENESIS PERRING	& PARKWAY		PARKU:	LLE.		BALTIN	TIRE	
Funeral				yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or Fo	
Director		218-38-4782	1 <b>2</b> M 2□F	64 Yrs.	World's Days	riodis iviiti.	Aug 31, 1	942 1	(any / now	
>		Usual Residence of Decedent  10a. State 10b. County	140				-			
Shoy	_	1	110	c. City, Town or Lo					10d. Inside City Li	
8a-1	ctc	Marylans		l,	3 Altimo	re			1 X Yes 2	
123a or 28a-1 show	Dire	10e. Street and Number	. 1 1		10f. Zip Code	_	10	g. Citizen of What (	•	
	Funeral Director	3015 ROSAliA	Id Avenue			215		u-s.	A.	
"neturel", or Itams	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of His Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.	
P	by F	1 Never Married 2 Marrie	If Yes, Give		□Yes 212No	Specify:			Uhite	
"neturel",	q p	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:					U U	Unite	
in in	Completed	15. Decedent's (Specify only highest		(Give	lent's Usual Occupat kind of work done du	ion iring most of work	ing	6b. Kind of Busines	ss/Industry	
r than "	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	IITO. I	OO NOT use retired)			DISA	ABLED	
		17. Father's Name (First, Middle, La	act)		DISA		- /5' 14'-4"		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ental Hyg kad othe ic event,	Be		Frouch Si	_	'	-	e (First, Middle, Ma	1 /	.)	
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f Health and Meritem 27 is marks other traumatic		19a. Informant's Name/Relationship			g Address (Street an					
m 27 m 27 her t			IER Muce	815.6	sition (Name of	TANO	H BA	HIMORC		
if of H		20a. Method of Disposition / 1≯ Burial 2 ☐ Cremation 3	R Pemoval from State	cemetery, cren	natory or other place)	) !		oc. Location - City of		
tr y		`4 □Donation 5 □ Other (Spe	ecify)	DAKI AWO	J Cemeter	y JAN	12,2007	BALTIMO	ive MATH	
E E E		21. Signature of Juneral Service Lie	censee	22	Name and Address	Facility 7	vuino.	LICENSE	LIZZY	
eny eny eny		WHZ-	-	4	120 5 H	-himin	he Bal	60 MD	2/27/	
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the	death. Do not ente	or the mode of dying,	such as cardiac	or respiratory arres	t,	Approximate	
nysician		Immediate Cause (Final							Interval Betwee Onset and Deal	
Medical		disease or condition resulting in death)	Due to (or as a co	incontrop of					YEARS	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2007 01058 Douglas Canham

		1- For State Registrar	Ce	rtifica	te of	Death				Reg. No	Fran (		/ 1100
Physicia Medical Exami		Decedent's Name (First, Middle, Last)     Douglas Paul Canham							Date of De Month	Day	Yea	ır	3. Time of Death
		4a. Facility Name (if not institution, give street and number	r)		4	b. City, Town, or Lo	ocation of		January		c. County c	of Death	1647 hrs
		Harbor Hospital				Baltimore					N/A		
Funeral		014 70 0704	ge (In yrs.	last birth	day)	If Under 1 Year Months Days						9. Birt Foreig	thplace (State or
Director		214-78-9791 1X <sub>M</sub> 2_F	50		Yrs.	Months Days	Hours	Min.	09/17	/1956	5	Col	untry) MD
any		Usual Residence of Decedent  10a. State 10b. County	10c. City	Town o	r Locatio	20							10d Inside City Limits
ž ,	<u>.</u>	MD N/A		cimore		J. 1							1 X Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number	1 241	- IIIIOI C	_	10f. Zip Code				10a Cit	izen of Wh	at Cour	
th the Maryland 23a or 28a-f sho notifie <u>d at once</u>		23 W. West Street				21230				U.S.			,
n with ms 23 be no	eral	11. Marital Status 12. Was Deceden		J.S.	13. Was	Decedent of Hispa	anic Origi	n? (Spec	ify Yes or N	0.3.	14. Race		can Indian, Black,
r deat	Fun		X No			s, specify Cuban, N		Puerto Rii	can, etc.)		White	, etc.	
rs afte ural",	þ	Widowed 4 Divorced If Yes, Give Year or Dates:  15 Decedent's Education (Specify only highest grade co	mplotod)	160 D		Yes 2 X No				Lini	Specify:	Whi	
72 hou	eted	Elementary/Secondary (0-12) College (1-4 or				st of working life. D				166.	Kind of Bus	ıness/ir	ndustry
5-0036 led within 72 Hygiene other than the Medical	Comple	12		Gard	lener					La	ndscap	ina	
15-0 filed w Hygid d othe	ပ္ပ	17. Father's Name (First, Middle, Last)							irst, Middle,				
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	To Be	Donald M. Canham  19a Informant's Name/Relationship (Type, Print.)		1406	Marlina			J. C					
O g B z z	_	Glenda J. Anderson, Mother		T		Address (Street a						, State,	Zip Code)
		20a Method of Disposition	20b.	Place of	Disposit	anley Drive	etery,		ate			City or	Town, State
More Pages I. nent of H annt: If it		1 X Burial 2 Cremation 3 Removal from S 4 Donation 5 Other Specify:	tate Hi al	cremator hview		erplace) orial Garden	ns I	01/20/	/20 <b>0</b> 7	F:	alletor	o Ma	aryland
Baltimore, permit Pages I an Department of Hea Important: If iten		21. Signature of Funeral Service Licensee	۱۰۰۰ ج			ame and Address of		_	rd J.			1, 110	ar y ranu
_ ==		Olipandua Bates			530	)5 Harford 1	Road,	Ralti	more	MD 21	214		
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.					uch as car	diac or re	spiratory ar	rest, sho	ock, or hea	rt	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a Atherosclerotic Due to (or as a constitution of the condition of the condit			r Dise	ase							Death
		Sequentially list conditions, b	equence c	и)									
	iner	if any, leading to immediate Due to (or as a cons	equence o	of).									
. 9	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a cons	equence o	of):				_					
vecuted and - transit	a E	d											
	Physician/Medical	UNPENDED											
68760, ertificate be eding physicia	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy						230	Date of c				
Box 6 death cer he attendi	sicia	past 12 months?	t time of de			er (Specify)	Lotopic	rograncy		1143	Month	Da	ay Year
the death of the attenty the attenty the attent ched for us	Phy	Part II. Other significant conditions contributing to deat	la la di madi a		- 11	4-14			00 0				
P.O	ē	, are in States significant conditions — contributing to deat	n but not n	esuning i	n the un	derlying cause give	en in Part	, ,					ne cause of death?  ably 4 Unknown
ds, require seen si ould b	eted			_	_			- 1	24a. Was				opsy findings available
e law e has l ge 2 sk	Completed							_		rmed?	pr	or to co	mpletion of cause of
tal Records, P.O. Box 6 cian: The law requires that the death ce certificate has been signed by the attend ector, page 2 should be detached for use		25. Was case referred to medical				26.Place of	Death (C	heck only	1 Yes	2 N	0 1	<b>✓</b> Yes	2 No
<u>;                                    </u>	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2 🗸	ER/Outp	atient		her:	Nursing H		Reside	nce 6	Other.	
fing Ph After t	ٳؾۣ	27. Manner of Death 28a. Date of Injunction (Month, Day, Month, Day)	ury /ear)	28b Tir	ne of Inj	ury 28c. Injury a	at Work?	280	Describe	how inju	ry occurred	d	
Sior Artend death ctor: y the i	ätic	Pending  Accident Investigation				1 Yes		lo					
Division spital or Attent ours after death neral Director: filled in by the	Certification:	determined (Cassist)	njury - At ho	ome, farn	n, street,	factory, office build	ding, etc.	28f	. Location ( or Town, S	Street a State)	nd Number	or Rura	al Route Number, City
lospit 4 hour unerzely fill		29a Certifier 1 Continue Table 1	v knowled	ao doath	0000000	nd at the time, date			. A Ala .				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and menner stated	mination a	nd/or inv	estigatio	n, in my opinion, de	eath occu	rred at the	e to the caus e time, date	se(s) and and pla	d manner a ce, and du	s stated e to the	cause(s)
F 3 F 8	Me	29b Signature and title of certifier				29c. License n	umber			29d [	Date signed	1 (Mont	h, Day.Year)
		Alcon				O.C.M.I	E.			Janu	uary 17,	2007	
8		30 Name and address of person who completed cause of	,	,	_	01				-			
Sta	nte.	Susan Hogan MD. Assistant Medical E.  31. Date filed (Month, Day, Year) 32. Registra			Penn	Street, Baltim	ore, MI	2120′ د	l ———				· · · · · · · · · · · · · · · · · · ·
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		For State Registrar	State of N		Department of Certificate of		, ,	iene <sub>eg. No</sub> 2 N N 7	01059
Physici	an	Decedent's Name (First, Middle, L.)	,				2. Date of Deat Month	h Day Year	3. Time of Death
/Medio		4a. Facility Name (If not institution, g	Caris Ar			or Location of Death	January	13, 2007 4c. County of Dea	3:47 P M
LAdilli	ICI	6000 California			Rockv			Montgo	
Funeral Director		5. Social Security Number 218-66-7758 6.	Sex 7 1 ☐ M 2 🔀 F	Age (In yrs. last bird	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, May 18,	<sup>Year)</sup> 1955 Mas	thplace (State or Foreign ountry)
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limits
Maryl -f sho fied al	tor	Maryland Montgo	omery		Rockvi	11e			1 X Yes 2 □ No
th the or 28a a notif	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
oth with with 23a c	Funeral Director	6000 California	Circle, Un	nit 405	208	352		United St	ates
er de@ items ner m	nue	11. Marital Status	12. Was Deceder Armed Force	s?	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
irs aft il", or xamile	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates		1 ☐ Yes 2 🖾 No	Specify:		Specify: \[	Vhite
72 hou natura lical E	ted	15. Decedent's E (Specify only highest g.	Education	16a.	Decedent's Usual Occu	pation	·	16b. Kind of Business	/Industry
ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4o	or 5+)	(Give kind of work done life. DO NOT use retire	e during most of work. ed)	mg	Entertai	nment/
filed w Hygie ther t		17. Father's Name (First, Middle, Las	5+ st)		Actress	18. Mother's Name	(First Middle N	Theater	<del></del>
lld be lental ked o	To Be	Philip Corfman	.,				Luccock	· ·	
s mar	_	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Stree	t and Number or Run	al Route Number,	City or Town, State,	Zip Code)
and 2		Philip Corfman /	Father		17 Linden C			aryland 20	0814
ages 1 nt of H : If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		te 20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ace) Janu	ary	20c. Location - City or	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hygjene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Crem	gomery atorium Inc	ess of Facility Po		Bethesda,	
Dep lmp any		1		M01433	Rockville, Rockville,	Inc., 30	ชั่งธุรริ M 20850	ontgomery	uneral Home Avenue
Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ed the death. Do not line.  Shakke as a consequence of	ot enter the mode of dy			st,	Approximate Interval Between Onset and Death a few livery
ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence o					
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State Registrar

10

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marietta J. D'Amico January 15, 2007 8:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Heart Homes of Linthicum Linthicum Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 👿 F 217-05-3723 88 Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits worle 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23e or 28a-f ebov other traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Director Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6422 Oak Park Ct. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U. S. Army Counter Elementary/Secondary (0-12) College (1-4or 5+) Director Intelligence Corps 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be finent of Health and Mental 1 and: If item 27 is marked o Silvio Pecora Alma DeLuca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6422 Oak Park Ct., Linthicum, MD Joseph S. D'Amico 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Gardens of Faith Maus. 1/22/2007 Baltimore, Maryland `4 □Donation 5 XOther (Specify) Entombment 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee Tela 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Septicemia /Medical Due to (or as a consequence of): Examiner Left Foot 2-3 WECKS Gangrene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or #s.) consequence of): Peri haral Vascular Disease the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai ITTN detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Stroke or other acute Neurologic Completed Malnutation 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy OF uterine tumor MStory 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 ther (Specify) ASSISTED LIVING 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 07 H0061312 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.O. 660 KENILWORTH DRIVE, SUITE 206, TOWSON, MD 21204 SHAH 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:45 PM 1844 2007 Kenee Dudnikov Januar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA Baitimor Memorial Hospital 9. Birthplace (State or Foreign Country) Belgium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 138-26-6878 7,192 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Baitimore Baltimore Funeral Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA Farringdon 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 22 No Saltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DWA Home Home maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rache Zimmerman Dickstein ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore Karen Dudnikov Daugnter Farringdon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 ☐ Cremation January 19,2007 Hanover, MA Anadomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Fune al 21076 HODOURC, MP 7522 Connelley 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 days Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 □ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an mea? No certificate 1□ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural
2 Accident 5 ☐ Pending investigation Injury 1 Yes 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 184H AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital 21218

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (A

Registrar's Signature

Year)

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Arabella Diaz Salazar	State of Maryland / Department of Health and Mental Hygiene	3	0007	0.1
1- For State Registrar	Certificate of Death	Rea No	2007	Ul

rabella Diaz S	alaz	1- For State Registrer Certificate of		ygiene Reg f	200	7 01062
Physici ledical Exam				Date of Death     Month     Da	ay Year	3 Time of Death
Action Exam	ille	Arabella Helene Salazar Diaz  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	January 16, 2	4c. County of Death	1319 hrs
		Good Samaritan Hospital	Baltimore			/a
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	s. 8. Date of Birth (N	M/DD/YYYY) 9 Birl	thplace (State or
Director	ì	219-75-4360 <sub>1 M 2</sub> X <sub>F</sub> n/a <sub>Yr</sub>	Months Days Hours Min	July 12	Foreig	Towson, untry)Maryland
,		Usual Residence of Decedent		1041/12	72000	Maryland
w any		10a. State 10b. County 10c. City, Town or Loca	tion			10d. Inside City Limits
daryland 28a-f show 1 at once.	ģ	Maryland Baltimore County Baltimore				1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director		10f. Zip Code		Citizen of What Cour	
rith th 23a 10tif			21234 as Decedent of Hispanic Origin? (Sp		United Sta	
eath w items	Funeral	1 Never Married 2 Married Armed Forces? If	res, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
ffer d	by Ft		Yes 2 No specify: Gua	temalan	Specify Hisr	panic
hours af "natural".	d b		nt's Usual Occupation (Give kind of vinost of working life. DO NOT use reti	work done 16	b. Kind of Business/li	ndustry
336 thin 72 h re. than "r edical E	oleted	Elementary/Secondary (0-12) College (1-4 or 5+)		red)		
5-0036 led within 72 Hygiene. other than the Medical	Comple	n/a n/a n/a	n/a		n/a	1
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C			(First, Middle, Maid	/	
ID 21215-003 should be filed withing and Mental Hygiene. 7 is marked other the matic event, the Med	To E	Emerson Salazar Diaz  19a. Informant's Name/Relationship (Type, Print.) (Parents)  19b. Mailin	g Address (Street and Number or I	Krystal Mc Rura Route Number	City or own, State.	Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygens or 17 is marked other than "natural", or items 23a or 28a-f she tranumatic event, the Medical Examiner must be notified at once		Emerson & Debbie Salazar Diaz 5 Dur		.A4 Balti	imore,Mary	land 21234
9 _ = = -		20a. Method of Disposition  20b. Place of Disposition  Removal from State  20b. Place of Disposition  Removal from State	sition (Name of cemetery, ther place)	1	c. Location - City or	Town, State
Imore Pages 1 nent of H ant: If i		1 XBurial 2 Cremation 3 Removal from State crematory or of Moreland	Mem.Park Jar	1.19,2007	Parkvil	le,Maryland
Baltimore, permit Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Paceful Alternati 325 York Road 1	Vec Funor	-alsCromat	ion Ctra D
		Jeffy f. Javi, 22 P.	325 York Road	imonium,	Maryland	21093
Physician /Medical		239 Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line		r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Sudden infant death in infant death death in infant death	tancy (SIDS)			Death
		Sequentially list conditions, b				
	ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
-	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
ecuted and transit	<u>n</u>	d				
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760, ficate be exe g physician the burial -		23b Was decedent pregnant in the			23d. Date of delivery	
Sox 687 death certific e attending p	ciar	past 12 months?	etal death 3Ectopic pregna ther (Specify)	incy	Month D	ay Year
Bo, e death the att	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	пет (Ореслу)			
hat the ed by letach	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to t	he cause of death?
S, P.( uires that n signed Id be deta		ļ		1 Yes 2	No 3 Prob	ably 4 🗸 Unknown
cord law req has bee 2 shou	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Rec The la	ğ			performed 1 <b>Y</b> Yes 2	l? death? No 1 ✓ Yes	s 2 No
tal Recinn: The certificate ector, page	Be	25. Was case referred to medical examiner?	26 Place of Death (Check	only one)		
f Vi Physic or this	ဥ	1 Yes 2 No Trospital 1 Inpatient 2 V ER/Outpatient			idence 6 Other	
nding nding h. Afte	i.i	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of	Injury 28c. Injury at Work?	28d. Describe how i	injury occurred	
isio Atter er deat rector by the	icat	2 Accident Investigation 28e Place of Injury At home form street		28f Logation /Stree	t and Number of Due	al Route Number, City
Divis pital or A ours after of	Certification:	Suicide 6 Could not be determined (Specify)	ot, factory, office building, etc.	or Town, State)		al Route Number, City
Division of Vital Records, P.O. Box 68760, Inopiral or Attending Physician: The law requires that the death certificate be executed 24 hours after the end.  Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, and	due to the cause(s)	and manner as state	d.
Di To the Hospital within 24 hours a To the Funeral I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated				
F % F 8	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Mon.	th, Day, Year)
		aneta	O.C.M.E.	Ja	anuary 17, 2007	
		30. Name and address of person who completed cause of death (Item 23a)				
	Arriva)	Ana Rubio MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21201			
S Regis	tate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Al 1			
1.0910	1	a FOOT Amelianor No.				

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician 3<u>,</u> 2007 3:10 PM M January Dorothy A. Disney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Owings Mills Baltimore 26 Deerlodge Court | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 24, 1923 5. Social Security NumbelUnk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 83 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28e-f ehow the Madical Examinar must be notified at 1 Yes 2 No Funeral Director Baltimore Owings Mills 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21117 26 Deerlodge Court USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dail Hygiene.
other then "naturel", or Item Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No δ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk permit. Pages 1 and 2 should be filed Depertment of Heelth and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, i unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Baltimore County Police Dept 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 N Other (Specify) in state 21. Signarur di Fundal Service State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** d D Cun /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) been signed by the sample should be deteched in 1 Yes 2 HO 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 → Yes 2 → No Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 🗌 Inpatient 2 ER/Outpatient 3 DOA the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident efter deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerel I completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a, Certifier To the within 24 and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walken Ken 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i> :	artment of F rtificate of		Mental Hy	/gien	-001	01064	
	Discorter		Decedent's Name (First, Middle, I	•				2. Date of De Month			3. Time of Death	
	Physici /Medio		James Dugo	an				JANUAR		_	5:20 PM	
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			Baltimore Vetera		1		imore					
	Funeral Director		5. Social Security Number 160–14–6184	Sex 7. Ag 1 ★ M 2 ☐ F	e (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, Da Mar 1,	rth ay, Year 191	9. Birthpl Coun	lace (State or Foreign try) ylvania	
	pu ,		Usual Residence of Decedent									
	arylar ahow	_	10a. State 10b. County		10c. City, Town or Lo					10	Od. Inside City Limits	
	death with the Maryland ma 23a or 28a-f ahow rminat ba notifiled at	Director	MD Cecil		Conowin						1 ☐ Yes 2√∏ No	
		al Dir	10e. Street and Number 775 Ragan Road			10f. Zip Code	21918		10g. C	itizen of What Coun USA	try?	
ING Z IZ 15-0050 be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural", or itema 23a or 28a-f ahow event, the Madical Examinat must be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 41-45	1□Yes 2█No			0-	14. Race - America Black, White, e Specify: Wh	etc. ite		
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2	e file of he vent,	Bec	17. Father's Name (First, Middle, La	st)			18. Mother's Nam	ne (First, Middle	, Maide	n Sumame)		
/and	should be nd Mental marked o	ToE	Michael Duga	ın			Eliza	beth Co	one	у		
<u>.</u>	2 should and Men is marke sumatic	ļ.	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rui	ral Route Numb	per, City	or Town, State, Zip	Code)	
≥	s 1 and 2 of Health item 27		Dennis Dugan/so	n			treet War	etown,	NJ	08758		
Saltimore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 4 ☒ Donation 5 ☐ Other (Special Contents)		20b. Place of Dispo cemetery, crea	sition (Name of matory or other pla	сө)	Date	20c. L	ocation - City or To	wn, State	
Dall	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Sarvice He	ensee leasant			Soffy Board		. Ва	ltimore S	treet	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_a_ Cor	the death. Do not en	er the mode of dyli		or respiratory a	arrest,		Approximate Interval Between Onset and Death	
	tificate be executed by physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):									
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.O. BOX 0	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnance Other (specify)	у			23d. Date of deliver Month	ry D <i>a</i> y Year	
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VISION	anding F sath. or: After he funer	atlon	27. Manner of D  1 Natural 5 ☐ Pending 2 Accident investigat		y Year) 28b. Time o Injury	Wo	ryat rk? Yes 2 □ No	28d. Describe	how inju	iry occurred		
<u> </u>	al or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location ( City or To	Street a	nd Number or Rural e)	Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2.	ledical C	29a. Certifier Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner sta	examination and/or in	n occurred at the till vestigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s date <i>a</i> n	s) and manner as sta d place, and due to	ited. the cause(s)	
	To the within To the Comp	ž	29b. Signature and title of certifier	0		29c. Licens	se number		29d. Da	ate signed (Month, D	Day, Year)	
			30. Name and address of per wh	This, MD	eath (Item 22a) /Turn	Oriot)	1754	0	Jan	uary 14)	2007	
			USMAN ZAH	IR M.D.,	ID N. GRE	EN ST.	BALTIM	ORE,	MD	21201		
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1	32. Registra	ar's Signature	parle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 5:12 A M Davis Fric January 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Balt: merc If Under 1 Year If Under 24 Hrs. of Baltimore Singi Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 10M 2□F 215-78-614 Director Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at NA 1 Yes 2 No Baltimore Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Ave. USA orest Hark 21215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours atter to Department of Heelth and Mental Hygiene important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Ferri Black, White, etc. 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Iransporter University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alverta Joseph rice 19b. Mailing Address (Street and Number or Pyral Route Number, City or Town, State, Zip Code)
2514 W. Frest tark Avenue 19a. Informant's Name/Relationship (Type, Print) Campbe 11 Mrs. Alverta Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Carnel Cem. 20/01 4 ☐ Donation 5 ☐ Other (Specify) l 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph 2222 Min No 12 14/6 faires 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asthma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed pue Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physiclen hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) director, page 2 should be detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown Deen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 No 2 X ER/Outpatient 3 □ DOA this: After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural ours after death.

nerei Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aff To the Funerel DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 059062 January 15 MA

Registrar DHMH 17 Rev 1/2001

State

Baltimore

W Belvedere

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2007

1

2401

Chad J. Hansen

31. Date filed (Month, Day, Year)

			State of Maryland / Department	artment of Health and Me rtificate of Death		2007 01066
200	à		Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	g. No. 3. Time of Death
	Physici		Mary D. DeWitt	т	Month anuary	Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	anuar y	4c. County of Death
	LAGIIII		Heritage	Dundalk		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	3. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country)
	Director		220-07-1582 <sup>1□M 2</sup> √2F 85 Yrs.		2/12/1	'
	pu s		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	faryla sho	ō	MD Baltimore Dunc			1 ☐ Yes 2 ☐ XNo
	the N 28a-i	Director	10e. Street and Number	10f. Zip Code	10	lg. Citizen of What Country?
Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		7232 German Hill Road	21222	10	US	
	Funeral		Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No-	14. Race - American Indian,	
	urs after or all, or iter	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No	If Yes, specify Cuban, Mexican, Puèrio Ri 1 ☐ Yes 2 🏿 No Specify:	ićan, etc.)	Black, White, etc.  Specify: White
Ş	72 ho natur lical I	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	1	6b. Kind of Business/Industry
7	ithin 'ne. nan "	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	kind of work done during most of working DO NOT use retired)		- 1
7	lygier ner th		OLII	emaker		In own home
and and	be fi	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (	rirst, Middle, M	laiden Surname)
ž	hould d Mei marke maric	Ը	Louis Weindl  19a. Informant's Name/Relationship (Type. Print) son 19b. Mailli	Anna ng Address (Street and Number or Rural)	Pauta Numbor	City or Town Chata Tin Code)
2	nd 2 salth an 27 is i			) Kavanagh Rd, B		
	Hea Hea			position (Name of matory or other place)		20c. Location - City or Town, State
E 0	0		1 Surial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify)  Holy Re	14 / 00 /	2007 B	altimore, MD
Baltimore,	permit. Pag Department Important: I any Injury c			2. Name and Address of Facility Jos	eph N.	Zannino Jr. FH
ñ	an In Ger					timore, MD 21224
			23a. Part1. Enter the disease, if complications that caused the death. Do not enshock, or heart failure. I ist only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arre	st, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	HEART FAIL	URE	Onset and Death
+	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).			
/	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury)	RUCTIVE PULM	SUCARY	DISFACE
ĵ.	execun and ial-tra	Еха	that initiated events resulting in death) Last  c. United Wile William Co. Due to (or as a consequence of):	ACTIVE TUCIO	ren ich	373012
8/60	certificate be executed rding physician and use as the burial-transit	dical	d			
٥	rtifica ng ph as th	Ned	IE FEMALE.			
X Q Q	ath ce tendii or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	□Ectopic pregnancy		23d. Date of delivery
5	ne death the atten hed for u	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month Day Year
1	hat the		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I	23e Did toba	acco use contribute to the cause of death?
ds,	w requires that the death certifit been signed by the attending f should be detached for use as	d by		given in taken	1 ☐ Yes	
ecora	w req been shoul	Completed			24a. Was an	24b. Were autopsy findings available
r	sIclan; The law certificate has b irector, page 2 sl	ш			autopsy perform	prior to completion of cause of death?
<u>ra</u>			25. Was case referred to medical	26. Place of Death (		IDMo 1 □ Yes 2 DNo
>	> .0.70	o Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien	Other: _		nce 6 Other (Specify)
5	ding Phys h. : After this funeral dir	n: T	27. Mann Peath 28a. Date of Injury 28b. Time of			w injury occurred
Ö	ath. Dr.: Af	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
UNISION	r Att ter de lrecte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stress building, etc. (Specify)	reet, factory, office 28	Bf. Location (Street, City or Town,	eet and Number or Rural Route Number, State)
ב	oital curs af	Se				
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	in occurred at the time, date and place, an exertigation, in my opinion, death occurred	nd due to the ca d at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within To the compli	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
			Scentrada 11 TIOLICA M	D D27180		1/18/07
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) D/		1 10/0/
			Savinder IL Julko ZMar	sket l'ace D	LIND	ALK NED 2-1222
	Sta		31. Date filed (Month, Day, Year) IAN 1 9 2007	di)		
	Registr	ai	THIS TO LOS IN 199	70		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2:45 PM Evelyn Mae Dicus 16,2007 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Bayview Medical Ctr. Baltimore City If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🔀 F 77 175-24-1710 28,1929 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Bel Air 1 ☐ Yes 2 🖾 No Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1920 Beech Street 21015 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: White 34⊠Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Cook Sweet Hart Cup Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph E. Claycomb Olive Bowser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rose Braman (Daughter) 1920 Beech Street Bel Air, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 1/19/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) POTENSION Sequentially list conditions, in any sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NUTRITION IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SACRAL DECERBI 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28d. Describe how injury occurred 1 tural

**Physician** /Medical **Examiner** attending physician and for use as the burial-transit the death certificate be executed

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The law requires that

Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director,

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**Physician** 

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Interpretant: filems 23a or 28a-f show Important: filems 72 Is marked other than "natural", or items 23a or 28a-f show any injury or form trawmatic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed Be ျ Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?	
1 ☐ Yes 2 ☐ No	
27. Manner Ceath	

Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Dunsale MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Medical

Sevindy 31. Date filed (Month, Day,

32. Registrar's Sign

who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

within 24 hours after dea To the Funeral Director completely filled in by th 10 Registrar

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HOO 58032 Milliano DO 1-16-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O. 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 22. Registrar's Signature State

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Roscoe Elliott Dann, Jr. 4:18 p January 15, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burtonsville Montgomery County Holy Cross Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 XM 2□ F 265.28.2691 Director October 17, 1925 Florida Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Madical Examinar must be notified at 1 Yes 2 No Director Howard Columbia Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A 6216 Bright Plume 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amfed Forces? 1 A Yes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1949 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: à Specify: White 3 Widowed 4 Divorced 1966 Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Army Elementary/Secondary (0-12) College (1-4or 5+) Major 5+ Pages 1 end 2 should be filed vent of Health and Mental Hygis int: if item 27 is marked other t 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grace Isabella Bosshardt Roscoe E. Dann, Sr. ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6216 Bright Plume Columbia, Maryland 21044 Mrs. Elfriede K. Dann Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 □ Burial 2 Cremation 3 □ Removal from State permit. Page Depertment of Important: if any injury or once. All County Cremation Services, Inc. 01/17/2007 Sykesville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility llembelle Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 1400533 Part1. Enter the disesses shock, or heart failure. I or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** metastatic enocarcinació cesión disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner signed by the ettending physicien and the detached for use as the human The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confibute to the cause of death? cete hes been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2☒No 24a. Was an 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Phursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ◯XNo 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeral Dire 29a. Certifier \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054566 16/07 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MM, 1220 A East-Joy paroud Skit 230 DWSON MADLIE Sun Ka Hogalili 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature State wares JAN 19 2007 Registrar

		-	For State Registrar	State of Maryland	d / Depa		of He	alth and M	iental Hy		2007	01070	
			Decedent's Name (First, Middle, Las	it)					2. Date of Dea		Vasa	3. Time of Death	
	Physicia		Angela Cook Eut	sler					Month	Day	7 Zoo7	3:30A M	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, 7	Γown, or L	ocation of Death	1,1000	4c.	County of Death		
	LAGITIT	Summit Park Nursing & Rehab Ctr Catonsvi										nore	
	Funeral		Social Security Number     6. Security Number			If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	v Vear	9. Birth	place (State or Foreign ntry)	'
	Director		220-07-0517	□M 2  ▼ 86	Yrs.	1410/11110	Duyo		June 30	19	920 Mary	1and	
	p .		Usuel Residence of Decedent  10a. State 10b. County	10c City	, Town or Loc	eation					<u>γ</u>	10d. Inside City Limits	-
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	with t	급	10e. Street and Number 12070 Century Ma	nor Drive		10f. Zip	Code	20754		rog. Oil	USA	,	
	s 23,	Funerai		12. Was Decedent Ever in U.	S 13 V	Vas Deced	ent of Hist		ecify Yes or No	)_	14. Race - Amer	can Indian,	-
	er d	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	If	Yes, spec	fy Cuban,	panic Origin? (Sp Mexican, Puerto	Rican, etc.)		Black, White	, etc.	
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215	hin 7	pie	(Specify only highest gra	College (1-4or 5+)	life. C	O NOT us	e retired)	ring most or work	"Ig				
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pu	al Hy d oth	Bec	17. Father's Name (First, Middle, Last)					8. Mother's Nam			Sumame)		
<u>8</u>	Ment Ment arke	ဥ	Elmer Ellsworth (					Lyda Pea					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be motified at once.		19a. Informant's Name/Relationship ( Angela Warfsman)					Manor D				20754	
ē,	Hea Hean tem	1	20a. Method of Disposition	1 0	lace of Dispo: emetery, cren	sition (Nam	ne of		Date	20c. La	ocation - City or T	own, State	
ê ê	Page: ent o nt: # ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification )	Removal from State	omotory, oron	ratory or or	p.a						
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	n. Do not ente	er the mod	e of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final					ICLE			10	Onset and Death	cc
3	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence		<u> </u>	1 1 7	1000			, 7	1000 0000	•2
- 1	Examiner												
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	phys the			d									
Box 68	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the t	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregna	incy						23d. Date of deli	verv	
Bo	atten for u	ä	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	I death 3	Ectopic pr					Month	Day Year	
o.	he de the ched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		20	,,	-350,000					
£ 0.	that I		Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying c	ause giver	n in Part I.	23e. Did 1	tobacco	use contribute to	the cause of death?	
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_) <del>∑</del>	sicia certi recto	Be C	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital: 1 Inpatient 2	ED/Outpation	nt 3 DC	Other				6 ☐Other (Spec	260	
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75 LE Division	Attending r death. actor: After	fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of injuly - At its	ome, farm, str	eet, factor	y, office		28f. Location ( City or To			ral Route Number,	
2 5	is after or selection of the selection o	Certification:	4 Homicide	building, etc. (Specif	y)				Ony or 70	WII, SIAI	<b>-</b> /		
Ĭ,	To the Hospital or Attanding Physician: The law requires that the death cert within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier Check only one)	hysicien: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death ation and/or in	h occurred vestigation	at the time i, in my opi	e, date and place inion, death occu	, and due to the rred at the time,	cause(s , date an	) and manner as d place, and due	stated. to the cause(s)	
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	Viti Co		Atron MA	> mv		(	000	6176	5	To	/A.M 1	7. 7007	
			30. Name and address of person who	completed cause of death (Item	n 23a) (Tyne	Print)					without 1	7	-
			1	UALNOC MO	3250	WIL	1CENS	6176	BACTIME	nŧ	wo 2	1229	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	<i>P</i>							
	Regist	rar	1.0 1.1 1.0	2007	HI	Lacalla	9						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Willie JATHUARY 7 Lee Evans 20 AM 900 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner BALTIMONE HAMILTON CONTOK GENESIS If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03-29-1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 F SC Director 216-58-2743 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show parmit. Peges 1 and 2 should be filed within 72 hours after deeth with the Meryle Depertmant of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumetic event, the Medical Examiner must be northed as 1 XYes 2 No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 21202 1201 N. Central Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Server 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Will Evans Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Grant. Antoinette Robinson daughter 1201 N. Central Ave., Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 01/20/07 Baltimore, MD King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home 21. Signature of Funeral Service Licanses M01452 2818 E. Baltimore St., Baltimore, MD21224 23a. Par1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner ULCER CUBITUS icien and buriel-transit the deeth certificate be exec ted Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. attanding physicien I for use es the burie Due to (or as a consequence of): Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown After this certificata has been signed by I funeral diractor, page 2 should be detach MULTIPLE MYCLOMA 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 ☐ No TITYES 2 1 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely fillad in by the 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 1 critifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number ATTENDING PHYSICIM DODGODST JANUARY 29b. Signature and titl. of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MAN NAME OF IND KN MODARIY. CETTER, GOYO, HARFORD HAMILZON G BNESIS

State

Registrar

31. Date filed (Month, Day, Year)

BARL !

\$2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2007 **Physician** JAN. Year 5:45 A<sub>M</sub> DOLORES M. ELLICK 12, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7904 SHORE RD. SPARROWS POINT BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖵 F Director 216-30-8128 72 MD. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD. BALTIMORE SPARROWS POINT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7904 SHORE RD. 21219 U.S.A. filed within 72 hours after death Hygiene. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fit thent of Health and Mental H tant: If Item 27 is marked ott Jury or other traumetic even GEORGE GRANSEE ANNA FLESACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE LANCASTER/DAUGHTER 7904 SHORE RD., BALTIMORE, MARYLAND 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o fmportant: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMETERY 1/16/07 BALTIMORE, MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Sprice Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Part1. Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Physician Metastatic 19 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 Unknown Completed 1 Yes 2 No page 2 should 24b. Were autopsy findings avaitable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes autopsy performed? 1 Yes 2 No Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ 2 ER/Outpatient 3 DOA After this 27. Mann- f Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: A М 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058893 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Browner MD Bayview 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0507 14 Fields 2007 harles aN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Vursing Len TOWSON silchrist 8. Date of Birth
(Month, Day, Year)

Aug 3, 1945 If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 2 □ F 61 216-44-1843 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Director 4daltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA Lanier 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 🗆 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. altimore, Maryland 21215-0036 Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Postal Tractor Trailer 11+1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) uanita Fields 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fannic Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation Garrison Forest Com Dwings Mills inco 4 □ Donation 5 □ Other (Specify) 24/07 21. Signature of Funeral Service Licenses Md 21215 Ra Baltimore Lowy 5240 Reisterstown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter or cannot Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the attending ph for use as t IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy perform Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 27. Manner of Death
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2 Accident 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation n 24 hours after death.

ne Funeral Director; Aft
bletely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29c. License numbe 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) W, 16565N. Charlesst. Sut 209/BestoMD endall Rtaykner MD Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 19** 

DHMH 17 Rev 1/2001

Registrar

2007

		For	ate of Maryland /			Mental Hygie	ene 0 0 7	01074
		State Registrar		Certificat	e of Death		. No.	
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/Medi	+	CLL++OKD +AG	AN	45 035	Town and anadism of Donath	DANUARY	4c. County of Death	1,50
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		5. Social Security Number 6. Sex	VURSING HO	oirthday) If Unde		8. Date of Birth	9. Birtho	lace (State or Foreign
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T and 2 Heelth em 27 ther tra		20a. Method of Disposition	20b. Place	of Disposition (Na	me of	Date 20	c. Location - City or To	own, State
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Daltillion  permit. Pag Depertment Important: i any injury o		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	100	22. Name a	nd Address of Facility	2000	HUDSON	CT,
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ysici ysici is cer direc	To B	examiner? 1 Yes 2 No Hosp	itat: 1 tnpatient 2 ER/	Outpatient 3 D	OA Other: Nursing I	lome 5 Residen	ce 6 Other (Special	(y)
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')		TASNEEM LAKHA		ARK HE	COME DIE	BALTO	M1) 21208	
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	)				
Regis	trar	<b>JAN 1 9</b> 20	07 Marian	K. Acast	23			

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			For State Registrar	State of Marylan	•	te of Death		2001	010/5
			Registrar  1. Decedent's Name (First, Middle, Last)		Ocitinda	to or beaut	Reg.  2. Date of Death	NO.	3. Time of Death
	Physici		Martha	1 Fu	V		Month Jonean	Day Year	2 09-20 AM
	/Medio Examin		4a. Facility Name (If not institution, give str	reet and number)	4b. City	Town, or Location of Death		4c. County of Deat	
	Zxamii	J.	Upper Chisape	ake Med. C	ta K	Del Air		Harto	rd
	Funeral		5. Social Security Number 6/Sex	7. Age (In yrs.	Months	er 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign untry)
5	Director		Usual Residence of Decedent	(4	o & Yrs.		7/8/38	WOL	DURN, MA
0	land		10a. State 10b. County	10c. Cit	y, Town or Location	1			10d. Inside City Limits
H	Maryland a-f ehow	호	MN Harfor	d	Falls	ston			1 □ Yes 2 No
8	or 28	Funeral Director	10e. Street and Number	1	10f. Z	ip Code	10g.	Citizen of What Co	untry?
0	death w	Ta	3dad Canter	bury Lai	ne	21047		USA	
1	er de	nue	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? (S) ecrly Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
04 6 1/15 b	irs aft	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: U	hite.
	2 hou	Completed by	15. Decedent's Educa	ation	16a. Decedent's Us	ual Occupation	ting 16t	. Kind of Business	Industry
715	en "r	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	rork done during most of wor use retired)	~ · · · · · · · · · · · · · · · · · · ·		1
25	ygian ygian t,	Sol	12	d	Selt-C	mployed	17	KANEL	Hgent
立	be fill d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Mai	11	01/0
	2 should be filed within and Mental Hygisne. is marked other then sumatic event, the Ms.	10	HIDEX T 1.  19a. Informant's Name/Relationship (Typ.	anaill	10b Mailing Address	ss (Street and Number or Ru	ral Poute Number C	100	OVR_
Ma	s 1 and 2 should be filed within 72 hours after deeth with the Marylan f Health and Mantal Hyglene. Item 27 is marked other then "neturel", or fleme 23s or 28s-f ehow other treumatic event, the Medical Examinat must be notified at		19a. mormant's Name Assationship (19)	aughter	Soun Play	isom + Vallou	Ad Sterry	w + stown	· M. na12
Ę eʻ	es 1 and 2 of Health of Health fitem 27 i		20a. Method of Disposition	20b. F	Place of Disposition (N	ame of	Date 200	. Location - City or	Carlotte Section 1
V E	Peges ent of nt: # i		1 ☐ Burial 2 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		remetery, crematory of		9/17 5	cost Ho	11 MLA
Baltimore, Mary	permit. Pag Department importent: eny injury o		21. Signature of uneval Service Livese			and Address of Facility	1. Forest	HII MD 2	21050
3 0	88 5 8		mbuly 4.	surpo the	Evans	Funeral Chap	of & Cremont	ion Service	Es-BelAir
1			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that daused the deat cause on each line.	h. Do not enter the me	ode of dying, such as cardlad	or respiratory arrest.		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a.	Anoxic	Enceph	clopathy			12 hours
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	,			42224
7		i i	Sequentially list conditions, if any leading to immediate	Due to (or as a conseq	uence of):	<i>lmonell</i>			fees
d	By T Age	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
50	be execu	Exa	resulting in death) Last	Due to (or as a consec	uence of):				
760,	nte be nysicié ne bu	cal	d.						
4 7	eath certificate be executed attending physicien and for use as the burial-transit	Med	IF FEMALE:					1	
7 Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnant 1 Live birth 2 Feta	il death 3 □Ectopic			23d. Date of de Month	livery Day Year
	the de	ysic	1 ☐ Yes 2 KNo 9 ☐ Unknown	4□Pregnant at time of o 9□ Unknown	leath 5 Cher (	specify)			
ル <i>角 R Th A</i> Vital Records, P.O.	nding Physicien: The law requires that the death certifical eth. eth. rr. After this certificete hes been signed by the attending phy is funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	Part II. Other significant conditions conf	ributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute t	the cause of death?
RTH cords,	quires n sign ald be	D D					1 X Yes	2 □ No 3 □ P	robably 4 Unknown
X 3	s bee	Sete					24a. Was an	24b. Were a	utopsy findings available
A S	The la	E					autopsy performe	d? death?	completion of cause of 2 □ No
ital	ysicien: The law is certificete hes b director, page 2 s	Bec	25. Was case referred to medical examiner?				ath (Check only one)		
	Physic this ce al dire	2	1 □ Yes 2 No	7 -	ER/Outpatient 3 ☐ 1				ocify)
u u	ding P h. After 1 funera	on	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
Division of	death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm street facts	1 Yes 2 No	28f. Location (Stree	et and Number or R	ural Route Number,
Div	after after Direct	Certification:	4 Homicide determined	building, etc. (Speci	fy)	ory, ornor	City or Town, S		
_	To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fo					ed at the time, date and place			
	he Hc in 24 i he Fu pletely	edicai	(Check only 2 Medical Examin	ar: On the basis of examination and manner stated.	ation and/or investigation	on, in my opinion, death occu			
	To t To t	Σ	29b. Signature and title of certifier	44 🔾	2	29c. License number	290	. Date signed (Mon	th, Day, Year)
	_		1	vi)			70	nucy 13	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	20		30. Name and address of person who con	mpleted cause of death (Ite	m 23a) (Type, Print)	ATWO OD	Rd. BE	ZAIR	MD 21014
	<i>U</i>	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature				
	Regist		1511 4 0 0	00-	to all				

			For State	State o	f Marylan		artment of H rtificate of L		nd Mental Hy	-	007	01076
			Registrar  1. Decedent's Name (First, Middle, La.	st)			inicate of L	Jealii	2. Date of De	Reg. No.		3. Time of Death
	Physicia	an		,					Month	Day	Year	
	/Medic		Cornelius F. Fro		mhar)		4b. City, Town, or	Location of I	Januar		200 / county of Death	5:45 AM M
	Examin	er	10 12 20						Death		1.	
			5. Social Security Number 6. S		1 7. Age (In yrs.	last hirthday)	Annapol	LIS If Under 24	Hrs. 8. Date of Bi	-th	le Aruno	
	Funeral Director			<b>™</b> 2□F	88	Yrs.	Months Days		Min. (Month, D	ay, Year) 191	8 New	place (State or Foreign Intry) York
			Usual Residence of Decedent		- 00					., _,_	1 - 1	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Mar **	to	MD Anne Ar	unde1		Annap	olis					1 □Yes 2√√ No
	n the	irec	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
	23a c	ai D	1052 TA-Eaglewoo	d Road			21	403			USA	
	deed	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin	? (Specify Yes or N	0- 14	4. Race - Ameri Black, White	
2	or its		1 ☐ Never Married 2 X Married	1 [X] Yes If Yes, Gi	2 No		1 ☐ Yes 2 1 No	Specify:	dorto Thour, oto.,			nite
$\tilde{\xi}$	ours rei',	Completed by	3 Widowed 4 Divorced	Year or C		-46		ороспу.			specify. W	
5	72 h	ete	15. Decedent's Ed (Specify only highest gra	ducation de completed)		(Give	dent's Usual Occupa	furing most o	f working	16b. Kind	d of Business/Ir	ndustry unk
4	hen hen	E I	Elementary/Secondary (0-12)		1-4or 5+)		DO NOT use retired					
V	led v		12 17. Father's Name (First, Middle, Last,	4		2	salesperso		s Name (First, Middle	Afoidos S	· · · · · · · · · · · · · · · · · · ·	
2	be fi	Be	Herman Froeb						dith Field		umame)	
Š	d Me d Me nark natic	2	19a. Informant's Name/Relationship (	Tona Orial		105 14-10			or Rural Route Numb		T 04-4- 71	- 0 - 1 - 1
Z	d 2 sl th an 7 is r traur		Catherine Froeb/s						Road Annap			403
נ	1 an Heal em 2		20a. Method of Disposition	pouse	20b. P	·-	osition (Name of	wood 1	Date Date		ation - City or T	
2	ot of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐			emetery, cre	matory or other plac	θ)				2.00
	permit. Peges 1 and 2 should be filed within 72 hours elter deeth with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "neturel", or Iteme 23a or 28a-f show ship filury or other traumatic event, if a Medical Exaction must be notified at appea.		4 Donation 5 ☐ Other (Special Service Lices			2	2 Name and Address	s of Facility				
Ö	Deparimination of the parimination of the pari		21. Signature of Euneral Service Lice Ant Hony B	Pleas	ant				oard 655 V	V. Bal	Ltimore	Street
	_		23a. Part1. Enter the disease, or com	plications that	caused the deat		Baltimore ter the mode of dyin		21201 ardiac or respiratory a	arrest,		Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.		Andt.					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	(or as a conseq	C 1	Dryllin	la				
	Examiner			Due to	(or as a conseq	derice oi).	ť.					
		e	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conseq	uence of):						
	uted d ensit	m	cause. Enter Underlying Cause (Disease or injury that initiated events									
<u>,</u>	exec en en rial-tr	Examiner	resulting in death) Last	Due to	(or as a conseq	uence of):						
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00	og ph as th			-						1		
Š	h cer endir r use	N/	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		☐Ectopic pregnancy			23	3d. Date of deliv	,
	deat of for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)				Month	Day Year
	by the	hy	9 Unknown					***				· · · · · · · · · · · · · · · · · · ·
'n	gned be de	by	Part II. Other significant conditions	contributing to d	leath but not res	ulting in the u	underlying cause give	en in Part I.				the cause of death?
oras,	en si ould	ed	Julie	w	injue				_ 10	Yes 2□	No 3□Pro	bably 4 Dunknown
ပို	0 5 0	Completed	(acchou	wycho	aly				24a. Wa	s an	24b. Were aut	opsy findings available ompletion of cause of
ב	The ete h page	ŏ		'	1				perl 1 ☐ Yes	ormed?	death? 1 ☐ Yes	
	sician: The lew certificete has t lirector, page 2 s	Be (	25. Was case referred to medical examiner?					26. Place o	Death (Check only	one)		
	hysic his co	2	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆	Inpatient 2	ER/Outpatie		4 14012	ing Home STRes	idence 6	☐Other (Spec	rfy)
0 -	ing P		27. Mannet of Death 1 ☑Naturat 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o	Worl		28d. Describe	how injury	occurred	
20	eeth. or: A	cati	2 Accident investigation					Yes 2 □ No				
DIVISION	or Ati	Certification:	3 Suicide 6 Could not be determined	28e. Plac	e of Injury - At he ling, etc. <i>(Specil</i>	ome, farm, st (y)	treet, factory, office		28f. Location City or To	(Street and own, State)	Number or Rui	al Route Number,
ב	pital ours e ours e ours e	ပ္	20a Contition 10 Contituing Di						-1			
	To the Hospital or Attending Physician: The I within 24 hours elter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ledical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example (Check only one)	miner: On the I	e best of my kno pasis of examina nner stated.	wiedge, dea	nvestigation, in my o	oinion, death	place, and due to the occurred at the time	cause(s) a date and p	olace, and due	stated. to the cause(s)
	othe omple	Me	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month	Day, Year)
	- s + ō		) A				DE	7078	/	1-	12-19	
			30. Name and address of person who	completed cau	ise of death (Item	n.23a) (Type	Print) A	1020		- 1	100	
			Aditya Choora M	D look	idaelu.	Ave I	231 A	nnam	CIM all	214	0	
	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature		TIME	IVI IVI		~	
	Registi	ar	JAN 1 9	2007	Masure	K.	Goods					
DH	MH 17 Day 1/2	004										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:50PM Naomi Margaret Flink 2007 ah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Loch Raven Center Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 10,1933 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F 73 212-32-3825 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits nem 47 re marked other than "natural", or Items 23a or 28a-f ehor other traumatic event, the Madical Examinar must be notified at Baltimore Baltimore MD 1 ☐ Yes 2 No Completed by Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8806 Littlewood Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Tes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Heelth and Mental Hygiene. em 27 ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Hostess 2yrs land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Toft Lenore Souder ္ပ Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth Thomas O. Flink/husband 8806 Littlewood Road Baltimore MD 21234 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 nent of P ant: if ite Bayview Crematory 1/19/07 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ Baltimore MD permit. Page Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fureral Service Licensee 300 Mace Avenue Balto. MD Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed nding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) cete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed' 2 No 1 ☐ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending d Director: Affi 1 ☐ Yes 2 ☐ No 6 Could not be determined within 24 hours efter dea To the Funerel Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4202 O 6 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2:01PM 01 Mary Fauver 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🔀 F 65 Yrs Feb 18, 1941 Director 218-36-6588 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits a or 28a-f sh Director 1 ☐ Yes 2▼ No MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1920 Chipper Drive Lot 19 21040 USA "natural", or items 23a Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced th and Mental Hygiene.

7 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 clerk Dept of Motor Vehicles 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental Mary Elizabeth Schaffer Raymond Joseph Fauver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 is ury or other train Beverly Balton/sister 4404 Hooper Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any Injury of 4 Donation 5 \$\infty\$ Other (Specify) in state 21. Signature of Funeral Service Licens <sup>22</sup> Name and Address of Facility Board 655 W. Baltimore Street Pleasant wasa Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Femoral Alter Pseudochenry Ruptured **Physician** 24 disease or condition resulting in death) 415 /Medical Due to (or as a consequence of) Examiner Shock y povoleni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence or) Examiner and -trans physician a Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No the detached 9□Unknown 9 ☐ Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No Venus 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy certificate 1☐ Yes 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2□ No 1 Inpatient 2 ER/Outpatient 3□ DOA 10 this After th funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Iniun M 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the death certificate be executed P.O. Box 68760 Records, Division or Vital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the f To the Hospital

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signature and title of certifie

ancy

MA 3333 Clark 31. Date filed (Month, Day, 32. Registrar's Signature Year) Spark 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Su sun

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

CAIVELT

29c. License number

120054318

29d. Date signed (Month, Day, Year)

St Str 570 Baltinia MD 21218

		•	For State Registrar	State of	Maryland	•	artment of H		Mental Hygie	ene 007	01079
	*		1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Benjamin G.	Garland					January	12, 200	7 1320 PM
	Examin	_	4a. Facility Name (If not institution,	0 .	-	•	4b. City, Town, or	Location of Deat	h	4c. County of Dea	ith
			Sinai Hosp		Balti		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	O Pi	dhalana (State or Fareign
	Funeral			5. Sex 1 Styl 2 ☐ F	7. Age (In yrs. I	ast σιππααγ) Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear) C	thplace (State or Foreign ountry)
	Director		213-52-4218 Usual Residence of Decedent		57				11/22/19	149 Mary	yland
	yland how		10a. State 10b. County		10c. City	, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	Maryland		E	Baltimo	ore				1√ Yes 2 No
	or 28	Ole O	10e. Street and Number				10f. Zip Code		100	. Citizen of What C	ountry?
	deeth with the Maryland	ra	3114 West Garri			0 140		21215		U.S.A.	orizon Indian
	item item	Funeral Directo	11. Marital Status  1 ☑Never Married 2 ☐ Marrie	Armed For		S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	Black, Whi	
5	l', or	by F	3 Widowed 4 Divorced	nd 1 ☐ Yes If Yes, Give Year or Da	0		1 ☐ Yes 2 No	Specify:		Specify: Bla	ack
2-003p	72 hours atter 'natural', or ite dical Examina		15. Decedent's			16a. Dece	dent's Usual Occup	ation	rking 16	6b. Kind of Business	s/Industry
7	within 7 ene. then "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT use retired	d)	in in its		
V	filed wi Hygien other th	Co	10			Jä	anitor	40 Markada Na	- Cina Middle M	Hospital	
ana	be fill double of the fill of	Be	17. Father's Name (First, Middle, L	ast)					me (First, Middle, Ma	ilden Sumame)	
5	2 should be n and Mental is marked ( reumatic ev	P	James Garland 19a. Informant's Name/Relationsh	in (Tyne Print)		19h Maili	ng Address (Street	Viola W	heeler ural Route Number, (	City or Town State	Zin Code)
2	treur		Margaret Flemin		<b>~</b>		Parsons 7		5-337	renue 2120	1
ย์	s 1 and 2 should be liled within 72 hours atter deeth with the Marylan if Health and Mental Hygiene. I the little and Mental Hygiene then antice the marked other then "natural", or iteme 23s or 28s-1 show other treumatic event, it a Medical Examinar must be notified at		20a. Method of Disposition	a / sisce	20b. P	lace of Dispo	osition (Name of matory or other place			c. Location - City o	
e E	Pages ent of ht: If I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐Removal from Secify)	state	•		1	0/2007 Ba	altimore	Maryland
Бащто	permit. Pages 1 an Depertment of Heal Important: If Item 2 eny Injury or other 20058.	1	21. Signature of Funeral Service L		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						F/H, P.A.
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			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplication that canny one cause on ea	aused the death ach line.	n. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arres	t,	Approximate Interval Between
, I	Physician		Immediate Cause (Final disease or condition	- Acu	te N	14000	ordial -	Infarc-	tiun		Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as a consequ						1
	LAGIIIIICI	-	Sequentially list conditions,	b. — Due to /	or as a consequ	uence of):					
b	nsit	lu lu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4							
<u></u>	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (	or as a consequ	uence of):					
		cal	3	d							
9	certificate iding physise as the	Med	IF FEMALE:						<u></u>		
X Q Q	leath certific ettending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fetal	I death 3	□Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
	the death in the death in the etternached for u	/s c	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregna 9☐ Unkno	ant at time of down	eath 5(	Other (specify)				
Į.	w requires that the de been signed by the i should be detached		Part II. Other significant condition	as contributing to de	eath but not res	ulting in the u	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
g,	requires that leen signed b hould be deta	d by	Diahetes	Melli	tus				1 ☐ Yes	2 No 3 P	robably 4 Unknown
ecord	w req	Completed	Hunger-	tension					24a. Was an	24b. Were a	utopsy findings available
e E	The law ste has b	m C	17 y per	[					autopsy	prior to death?	completion of cause of
VItal		0	25. Was case referred to medical					26. Place of De	1 ☐ Yes 2	XNO TO TO	5 2 10
<u> </u>	lysici iis cer direc	To B	examiner? 1 ☐ Yes 2 ▼No	Hospital: 1 🗆 li	npatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing l	Home 5 ☐ Residen	ce 6 ☐Other (Sp	ecify)
n o	ng Pt fter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	Wor		28d. Describe how	injury occurred	
<u> </u>	tendi leath. tor: A the fu	catl	2 Accident investig 3 Suicide 6 Could n	ation of he				Yes 2 ☐ No	001 11 (0)		
Division	or At offer d Direct in by	Certification:	4 Homicide determi	ned 289. Place	of Injury - At he ng, etc. (Specif	ome, farm, st	reet, factory, office		City or Town,		Rural Route Number,
_	spital ours cours neral (		29a. Certifier 1 Certifying	Physician: To the	best of my kno	wledge, dea	th occurred at the fir	ne, date and place	e, and due to the cau	ise(s) and manner a	is stated.
	To the Hospital or Attending Physicien: within 24 hours after death .  To the Funeral Director: After this certified completely filled in by the funeral director.	Medical			asis of examina				urred at the time, dat		
	To th within To th	Me	29b. Signature and the of certifier		11.		29c. Licens			d. Date signed (Mon	nth, Day, Year)
)			Product	& Fran	the	- MD	D	43470	6	Janvary	14, 2007
	K		30. Name and address of perso	o completed caus	e of death (Iten	n 23a) (Type	Print)  derick J	- E- :	. )		
			Sinai Hospit	al Baltin	nore,	Bros	derick J	rank	- lin, MD		
	Sta Regist		31. Date filed (Month, Day, Year)	2007 <b>32</b> : R	egistrar's Signa	iture	and the second				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 16, 2007 0845 A Virginia Lee Gosnell January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Havre de Grace Harford Harford Memorial Hospital 8. Date of Birth (Month, Day, Year)
Sept. 14,1940 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months 1 ☐ M 2 🔯 F 149-30-6246 66 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 X No Colora Cecil Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 21917 62 Spring Knoll Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12th Grade Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph Herbst Margaret M. Magill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George A. Gosnell, Jr. (Spouse) 62 Spring Knoll Ct., Colora, Maryland 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/19/2007 Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee 1 Inc. 610 W. Macphail Rd., Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancel Due to (or as a consequence of): Hemoptysis Sequentially list conditions, if any, leading to minisorate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 → ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

physicien and burial-transit been signed by the should be detached Division of Vital Records, P.O. within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,

Physician/Medical Completed by Certification: To Be Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

in then "natural", or items 23a or 28e-f ehow the Medical Examiner must be nutified at

Baltimore, Maryland 21215-0036

should be and Mental

permit. Pages 1 Department of H Importent: If ite any injury or ot once.

Physician

Examiner

/Medical

Directo

Completed

29b. Signature and title of certifier Stephance Linder MI

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. January 18, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 902 Averilled Jogga, MD Linder Stephanie

2007

31. Date filed (Month, Day, Year) State **JAN 19** Registrar

4 | Homicide

29a. Certifier

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:00 P M Billy Baxter Gullion January 17, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center @ GBMC Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1X M 2 □ F Director 226-28-6806 82 Dec. 10, 1924 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Machial Examiner must be notified at once. 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2221 Larchmont Drive Funeral 21047 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or itel 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electronic Engineer Electronic Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph Allen Gullion Sally Rose Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie B. Gullion / Wife 2221 Larchmont Dr., Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gran 1-20-07 | Fallston, Maryland 21. Signature of Funerah Service Licensee 22 Name and Address of Faculty Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications wontas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 1 ☐ Yes No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Dother (Specify) NOS D( U Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ★□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year) JAN 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

AARON

HMUES M 6701 N Charles St Barring up 21204 32. Registrar's Signature

29c. License number

D58303

29d. Date signed (Month, Day, Year)

Sanuary 17 200

			1 - State Registrar	State of	Maryland		artment of H rtificate of L		d Mental Hyg	giene	007	01082
	* 1		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Vear	3. Time of Death
Н	Physici /Medic		Anna Laurice Gard	ner					January	12', 2	2007	9:45 AM M
	Examir		4a. Facility Name (If not institution, give s Genesis Hammonds		ber)		4b. City, Town, or Brooklyn		eath		nty of Death 2 Arun	
	Funeral		Social Security Number     6. Sex		. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birth Min. (Month, Day	Year)	9. Birth	nplace (State or Foreign
	Director		217 11 0157	M 2	85	Yrs.	Bays	, 10210	Oct 28,		Mary	land
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	sho	ō										1√∑ Yes 2 □ No
	28a-	Director	MD  10e. Street and Number			рал	timore			10g. Citizen	of What Col	untry?
	with a or		1325 Webster Stree	r t				1230			SA	,
	na 23	Funerai			dent Ever in U.S	S. 13. V			(Specify Yes or No- uerto Rican, etc.)			ican Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itema 23a or 28a-f show aumatic event, the Medical Exacular met the rediffied at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Ford  1  Yes 2  If Yes, Give Year or Dai	2 <b>X</b> ) No		f Yes, specify Cuba 1 □ Yes 2🎇 No	n, Mexican, Pu Specify:	uerto Rican, etc.)	Spe	Black, White cify: W	o, etc. hite
ခို	tura afura	ed	15. Decedent's Edu			16a. Deced	dent's Usual Occupa	ation		16b. Kind of	Business/I	ndustry
15	filed within 72 Hygiene. hther than "nated ont, the Medic	Completed	(Specify only highest grade	completed)	4== 5 . )	(Give	kind of work done of OO NOT use retired	furing most of	working			,
212	r tha	E	Elementary/Secondary (0-12)	College (1-	401 5+)	house	wife			own	home	
פַ	othe othe	a l	17. Father's Name (First, Middle, Last)				·	18. Mother's I	Name (First, Middle,	Maiden Sum	ame)	
<u>a</u>	should be land Mental I amarked o	To B	Robert Lee Katz	enberge	er			Lillia	n Ann Kroi	ner		
Maryland 21215-0036	and N		19a. Informant's Name/Relationship (Type			(	-		Rural Route Numbe	-	vn, State, Z	ip Code)
Σ	and and a saith		Joanne Long/daught	er		1325	Webster S	Street	Baltimore	, MD	21230	
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic e gonce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)	emoval from S		ace of Dispo emetery, cren	sition (Name of natory or other place	θ)	Date	20c. Locatio	n - City or 1	Town, State
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service License Ant Lhony	Pleasa	nt nt		Name and Address tate Anat Saltimore	•	ard 655 W.	. Balt	imore	Street
- %:	- 3 - 5 - 5		23a. Part1. Enter the disease, of complishock, or heart failure. List only or	cations that ca	used the death					est,		Approximate Interval Between
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	/Medical		resulting in death)		r as a consequ		COLIC	CATON	10 VASCA	Crrc	עוע	4C MICS
311	Examiner		Sequentially list conditions									
53	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested executions)		r as a consequ	ence of):						
	icate be executed physician and s the burial-transit	Examiner	triat initiated events									
Ö,	e exe	EX	resulting in death) Last	Due to (o	r as a consequ	ence of):						
8760	ate b hysic the b	dlcai		l								
9	eath certific attending p	Med	tF FEMALE:	0 - 1/								
Вох	The law requires that the death certific tte has been signed by the attending p age 2 should be detached for use as	Physician/Me	23b. was decedent pregnant	1 ☐Live bir	ome of pregnar th 2 ☐ Fetal	death 3	Ectopic pregnancy			-	Date <i>o</i> f delin Month	very Day Year
o.	the s	ysic	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∐ Pregna 9□ Unknov	nt at time of de vn	ath 5∟	Other (specify)					
0.	res that the de signed by the a be detached f		Part II. Other significant conditions con	tributing to dea	ath but not resu	Iting in the u	nderlying cause give	n in Part I	23e. Did to	bacco use co	ontribute to	the cause of death?
Records,	uires sign	d by	_	WAC	FAIL				1 □ Υ			
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ě	has has	Completed	ULAMBETES I	MEST	1745				24a. Was a autops perfor	sy med?	prior to c death?	topsy findings available ompletion of cause of
	iician: The f certificate ha rector, page ;								1 ☐ Yes	2 No	1 🗆 Yes	2 No
Vital	sician: certifica irector,	Be	25. Was case referred to medical examiner?	lospital:			Othe		Death (Check only or			
ō	Phys r this ral di	To	1 ☐ Yes 2 (XNo 27. Manner of Death	1 ∐ in 28a. Date of		ER/Outpatien 28b. Time of	t 3 DOA		g Home 5 Resid			ify)
o	ding P	ţ.	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	injury	Work	(? Yes 2 □ No				
Division of	death death ctor: y the	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place o	of Injury - At hor	me, farm, str	eet, factory, office		28f. Location (S	treet and Nu	mber or Rui	ral Route Number,
2	l or At after d Direct	erti	4  Homicide	buildin	g, etc. (Specify,	)	,,,		City or Tow			
	To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1X Certifying Phys	sician: To the t	est of my know	vledge, death	occurred at the tim	ne, date and pl	ace, and due to the c	ause(s) and	manner as	stated.
	24 to Fu	Medical	(Check only one) 2 Medical Examination	ner: On the bas and manne	sis of examinati	ion and/or in	estigation, in my op	oinion, death o	ccurred at the time, d	late and plac	e, and due	to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certifical completely filled in by the funeral director,	×	29b. Signature and title of certifier	11.			29c. License			29d. Date sig		
	-		1/m ('w	yeu	an		D31	136	j	TANUA	24 /	2,2007 MD 21236
			30. Name and address of person who co	mpleted cause	of death (Item	23a) (Type,	Print)		2 0	y 1 y 3 1		2.2
			BRIAN C. WAL	LACT	mD.	900	5 KILB	RIDE	RO BAL	Imo	RE	MO 21236
4	Sta		31. Date filed (Month, Day, Year)		gistrar's Signat	ure			/		1	
-	Registr	ar	JAN 1 9 20	N7   /2		K B	ach s					

07-00457 Tyler Elwood Gayle

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce.	rtificate c		TIG WICHTEN		eg. No. 20	07 0108			
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last)  Tyler Elwood Gayle			•		2. Date of Dear Month January 1		3 Time of Death 1710 hrs			
		4a. Facility Name (if not institution, give sti			4b. City, Town,	or Location of Dea		4c. County of				
		University of Maryland Medic  5. Social Security Number 6. Sex			Baltimore	14			imore City			
Funeral Director		213 26 4009 1 M	7. Age (In yrs. I	ast birthday) Yr		ear If Under 24Hr ays Hours Mi	_	21 1930	9 Birthplace (State or Foreign Country <b>Urbanna, VA</b>			
any		Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Loca	ation				10d Inside City Limits			
vlaryland 28a-f show any 1 at once.	ō	Maryland Baltimore	Bal:	timore C	ounty				1 Yes 2 XNo			
vith the Maryland 2.23a or 28a-f shov protified at once.	Director	10e. Street and Number	- 0		10f. Zip Code 21234		10	0g. Citizen of Wha	at Country?			
with the is 23a cenotif		2901 Andorra Court Apt 11. Marital Status	. Was Decedent Ever in U	.S. 13. W		tispanic Origin? ( S	Specify Yes or No	USA - I 14 Race -	American Indian, Black,			
r death w or items	Funeral	1 Never Married 2 XXMarried 1	Armed Forces? Yes 2 XX No			an, Mexican, Puert		White,				
rs after ural",	۵	3 Widowed 4 Divorced If Y or 15. Decedent's Education (Specify only h	Dates:	1	Yes 2XX N			Specify:	White			
72 hou:	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during r	nost of working li	pation (Give kind of fe DO NOT use re		16b. Kind of Bus	iness/Industry			
0036 within iene rer tha	Completed	12	N/A	Gener	al Supervi			General	Motors			
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygene n 27 is marked other than "natural", or items 23a or 28a-f sh umartic event, the Medical Examiner must be notified at once	Be C	17. Father's Name (First, Middle, Last)  Major Dalby Gayle					ne (First, Middle, N <b>D Carlton</b>	Maiden Surname)				
2121 hould be fill ad Mental F is marked ttic event,	70 E	19a. Informant's Name/Relationship (Type	Print )			eet and Number or						
re, MD 2 s I and 2 shou of Health and M friten 27 is n	1	David W Gayle  20a. Method of Disposition	20b	_1	Babikow F	Road Balti	more, Mary		City or Town, State			
S L S L S L		1 Burial 2 Cremation 3	Removal from State	crematory or o	ther place)	: January			re, Maryland			
Baltimo permit Page Department Important: injury or ott	Ì	4 Dqnation 5 Other Specify: 2 On ture of Funeral Service Linensee				ess of Facility Uneral Home		DOTORIO	c, rarymana			
	_	23a. Part I. Enter the disease or complicat	Oho		7401 Rela	air Road Ra	ltimore M	laryland 21				
Physician /Medical		failure. List only one cause on each I	ne. ntact Gunshot Wour		the mode of dyin	g, such as cardiac	or respiratory arre	est, snock, or near	Approximate Interval Between Onset and Death			
Examiner		The second secon	to (or as a consequence o									
*****	Ē		to (or as a consequence o	f):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence o	f)·								
760, icate be executed physician and the burial - transit		d				<u> </u>						
760, icate be executed physician and the burial - transi	Medical		MENDED									
68760, certificate be nding physici se as the buri		IF FEMALE. 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg Live birth		etal death 3	Ectopic pregn	ancy	23d Date of d Month	lelivery Day Year			
Box 687 death certification of the attending of the as as the	Physician	1 Yes 2 No 9 Unknown		noth -	ther (Specify)							
O. B at the d d by the		Part II. Other significant conditions cor		esulting in the	underlying cause	e given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?			
of Vital Records, P.O. ng Physician: The law requires that the this certificate has been signed by nearl director, page 2 should be detact	ed by						1 Yes	2 <b>V</b> No 3	Probably 4 Unknown			
cords aw requirents been to should	Completed				-	<del></del>	24a. Was a autops perfor	sy pri	ere autopsy findings available for to completion of cause of eath?			
tal Rection: The certificate ector, page		25. Was case referred to medical			00.01	(5) 11 (0)	1 🗸 Yes 2		Yes 2 No			
Vital lysician:	o Be		tal: 1 🗸 Inpatient 2	ER/Outpatien		Other Nursi		Residence 6	Other:			
J of Jing Pli After 1 funeral	i.i.	27. Manner of Death	28a. Date of Injury (Month, Day Year) Jan 16, 2007	28b. Time of 1328 hrs		jury at Work?	28d. Describe h Subject shot	now injury occurred	t			
Division tal nr Attendi rs after death al Director: A	icati	2 Accident Investigation	28e. Place of Injury - At he			Yes 2 V No			or Rural Route Number, City			
Divis	Certification:	3 Suicide 6 Could not be determined	(Specify) Park/Recre			banding, etc.	or Town, St	tate) Drive, Overlea,				
Division of Vital Records, P.O. Box 68 To the Hospital nr Attending Physician: The law requires that the death certif within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated  29b. Signature and the of certifier 1 29d. Date signed (Month Day Year)											
F \$ F 8	ž	29b. Signature and lifte of certifier				nse number			d (Month, Day, Year)			
		30 Name and address of person who comp	leted cause of death //	232)	0.0	.M.E.		January 17,	2007			
14			nt Medical Examiner		nn Street, Ba	ltimore, MD 21	1201					
St Regist	_	31. Date filed (Month, Day, Year) <b>JAN 1 9</b> 2007	32. Registrar's Signatu	N	noth's							
		<u>v</u>	13 15 15 15 15 15 15 15 15 15 15 15 15 15	- X								

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed attending physician and for use as the burial-trai ed by the a sign I be Hospital or Attending Physician: director, After filled in by 24 hours a e Funeral i within 24 hor To the Fune completely fi

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Pages 1 and 2 should be

altimore, Maryland 21215-0036

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4 ☐ Homicide

(Check only one)

29a. Certifier

29b. Signatur

Medical

State

28f. Location (Street and Number or Rural Route Number, City or Town, State)

A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (III m 23a) (Type, Print)

and manner stated

LOW, TIMOTHY M. D 31. Date filed (Month)

7601 32. Registrar's Signature

OSLER DRIVE

Registrar

D24034

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9863 1-23-07 vt.
State of Maryland Poepartment of Health and Mental Hygiene Reg. No.200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 16, 2007 **Physician** Elisabeth S. Getschel 9:18 A M "/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Sanity Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕱 F 220-<del>40-</del>0754 94 Yrs. Sept. 6, 1912 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 X Yes 2 □ No **Funeral Director** Md. N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 120 Croydon Road 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Be Completed by 3 X Widowed 4 ☐ Divorced filed within 72 hours 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 5 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 is marked oth Shields Albert Sadie Smyth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: if Item 27 is
any injury or other trau Mr. Bruce Sawyer/ Son in Law 4 Waterbury Court Baltimore, Md. 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-18-07 Hilltop Service Co. Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service icense 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardid infruction **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 P.O. Box 68760, as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by たらいししてかいか has been sig te 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 | Yes 2 | No P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Rendelly my 29c. License number 29d. Date signed (Month, Day, Year) 1712808 1-17-07 ATTENDING PHYSICIAN #33 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TURK RUBA

DHMH 17 Rev 1/2001

Registrar

UTHERUILLE

21097

M JLL JAROALL.

32. Registrar's Signature

E

JAN 1 9 2007

WILLIAM

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RGARE MURY 4, 280% /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) 6. Sex Age (In yrş. last birthday, If Under 24 Hrs. Pate of Birth (Month, Day, **Funeral** 1 M 2 X F Months Days Hours Min Director MAR Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director 1 ¥Yes 2 No MARYLAND 10e. Street and Number Citizen of What Country? 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? natural", or Items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: BLAC þ Specify. 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiens Important: If Item 27 is marked other than any Injury or other traumatic event, the Monee. HIGRADE 00k HARLIE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JONES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ONNA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2 Sremation 3 □ Removal from State 1 D Burial 01-20-07 4 Donation 5 Other (Specify) METRO 21. Signature of Funer Service License BALTO, MP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Christian for the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for line of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Pulmo, an /Medical Due to (or as a consequence of): Examiner pticemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Jultiple physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. Certification: To Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this. 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 🗌 No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

0

State

30. Narfle and address of person who completed

9

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

			For State Registrar	State of Ma			irtment of H		Mental Hy	/gien Reg. N	2007	010	87
	-3	-	Decedent's Name (First, Middle, I	Last)					2. Date of De	eath		3. Time of De	ath $\rho$
	Physici: /Medic		William Oldham	Haney					Month Jant.	P.	Year 2607	5.05	M
Þ	Examin		4a. Facility Name (If not institution, g	,			4b. City, Town, or	Location of Death	1	4	c. County of Dea	th	
···			Washington Cou				Hagersto				Washing		
	Funeral		· ·	Sex 7. Age	e (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year	9. Bir	thplace (State or Fo ountry)	oreign
Э.	Director		227-18-9394 Usual Residence of Decedent	A	84				July 2	41,	1922 Vir	gínia	
	yland now at		10a. State 10b. County		10c. City, Town	or Lo	cation					10d. Inside City L	imits
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	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?	
	ath w	Funeral Director	114 Buttercup D					21740			USA		
	item item ner n	-un-	11. Marital Status 1 □ Never Married 2 🔯 Married	12. Was Decedent I Armed Forces?		13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S <sub>i</sub> an, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, Whit		
0000	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	40	1	☐ Yes 2X No	Specify:			Specify: wh	ite	
ž	2 hou		15. Decedent's		16a.	Deced	lent's Usual Occup	ation		16b.	Kind of Business	/Industry	
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<u> </u>	hould d Mer narke natic	T <sub>0</sub>	Herschel Glenn 19a. Informant's Name/Relationship		105	Mailin	a Address (Ctoop to		nia Comb		T 0::		
2	id 2 si Ith an 17 Is r traur		Nancy Haney/spo				g Address ( <i>Str</i> eet a <b>Buttercu</b> p						
ກົ	f Heal		20a. Method of Disposition				sition (Name of natory or other place		Date		ocation - City or	Town, State	
2	Pages ient o int: if i		1 ☐ Burial 2 ☐ Cremation 3 4 🗓 Donation 5 ☐ Other (Spe		cemeter	y, cren	natory or other plac	;e)					
Dallillor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. In Examinative 1 them 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euneral Service Lic ROPALO S	ensee Dir	ector	\$22 \$1	Name and Addres ate Anat	ss of Facility	d 655 W	. Ra	ltimore	Street	
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	/Medical Examiner		Todaling in addaily	~ 10	a consequence of	of):	0	vascula	, 1			2	
6		ē	Sequentially list conditions, if any, leading to immediate	b. A Thurs	a consequence of	of):	arello	vascuea	v du	eas		30 yrs	
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Ď ×	entific ling p		IF FEMALE:	00- 16									
S C C	eath c attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)	,			23d. Date of de Month	livery Day Yea	r
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ည ည	law re	plet	Renal Insu	Michney					24a. Was		24b. Were a	utopsy findings ava	ilable
	The ate ha	Completed		70					auto perf 1∐ Yes	ormed? 2 N	death?	completion of caus : 2□No	10 €
Z .	ertification ctor,	Be	25. Was case referred to medical examiner?					26. Place of Dea				20.10	
5	hysion this on	은	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie		<u> </u>		4 LI Nursing H	ome 5□ Res	idence	6 □Other (Spe	cify)	
	ing F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day		ime of njury	28c. Injur Worl		28d. Describe	how inj	ury occurred		
200	ttend death stor: / the	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 280 Place of init	In/ - At home, far	em etre	M 1 □	Yes 2 □ No	006 Location	/C44			
2	after after Direction by	Certification:	4 ☐ Homicide determine	building, etc	c. (Specify)	1111, 301	set, lactory, onice		City or To	wn, Sta	te)	ural Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after cleath.  To the Funeral Director, ther this certificate has completely filled in by the funeral director, page 2 to the property of the funeral director, page 2 to the funeral director, page 3 to the funeral director, page 4 to the funeral director, page 4 to the funeral director, page 5 to the funeral director, page 6 to the funeral director		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best	of my knowledge	, death	occurred at the tir	me, date and place	, and due to the	e cause(	s) and manner a	s stated.	
	the Ho in 24 the Fi	Medical	one)	aminer: On the basis of and manner sta	ated.	g/or in			irred at the time	, date a	nd place, and du	e to the cause(s)	
	To vith	Σ	29b. Signature and the of certifier	ON		1_	29c. License	e number		29d. D	ate signed (Mont	h, Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 3 **Physician** Year 200 /Medical 4a. Facility Name (If not institution, give street and numbe Town, or Location of Death 4c. County of Death Examiner ne anns Under 24 Hrs. 5. Social Security Number Sex (In yrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Months Days Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 1141 N. Stricker Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marita! Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No black Specify þ 3 Widowed 4 Divorced Year or Dates: Completed er than "nature, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bassemah El-Hagq Vaughan Lopx 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 600 N. Wolfe Street Baltimore, MD : If Item 27 i The Johns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of P Important: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Service Licensee Pleasant 28 Mart and Adda to The Board 655 W. Baltimore Street Myhony Baltimore, MD 21201 Dan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. pec the 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 4 Unknown 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 performed? or Vital 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 ☐ Yes ✓ Inpatient 2 ER/Outpatient 3 DOA this Funeral Director: After the stely filled in by the funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 □ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Płace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

29d. Date signed (Month, Day, Year)

200

within 24 hours the 10

nomaslee 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State o	f Marylar		artment of rtificate o				2	007	01089
		- 1	Decedent's Name (First, Midd)	le. Last)			inicate o	Death		2. Date of Dea	Reg. No	V V I	3. Time of Death
	Physici	an								Month	Day	Year	12:37 PM
	/Medio		Patricia Ann				45 Oits Town		- ( D 1)	January		2007	12.01 PM
1	Examir	ier	4a. Facility Name (If not institutio				4b. City, Town		of Death			ounty of Death	
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	Funeral			1 M 2 X F		. last birthday) Yrs.	Months Day		Min.	8. Date of Birt (Month, Day	, Year)	Cou	place (State or Foreign ntry)
de	Director		216-24-6137 Usual Residence of Decedent		80				l	Aug 16	, 192	6 Mary	land
	land		10a. State 10b. County	,	10c. C	ity, Town or Lo	cation					1	10d. Inside City Limits
	Mary f she	ō	MD Washi	ngton		Насе	rstown					-	1 □ Yes 2√ No
	the 1 28a- notifi	ect	10e. Street and Number			11460	10f. Zip Code	<del></del>			10a Citiza	m of 18/h of Oo.	
	with ber	급	1314 Potomac	A			Tot. Zip Code	21742	)		_	n of What Cou	ntry?
	s 23	era				10 140					USA		
	item item	Funeral Director	11. Marital Status 1 □ Never Married 2 Mar	Armed Fo		J.S.   13. ·	Was Decedent of If Yes, specify Co	i Hispanic Or Jban, Mexica	rigin? (Spi in, Puerto	ecity yes of No- Rican, etc.)	14	<ul> <li>Race - America</li> <li>Black, White,</li> </ul>	
36	rs aff	by F	3 □ Widowed 4 □ Divorced	If Yes Giv	/e		1 □ Yes 2 🗓 N	o Specify.	•		S	pecify: whi	lte
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	pa		nt's Education	atos.	16a Dece	dent's Usual Occ	unation			16h Kind	of Business/In	di cata
5	n 72 i "na ledic	Completed	(Specify only highe	est grade completed)		I (Give)	kind of work dor DO NOT use reti	e durina mos	st of work	ing	rob. Killu	or pusiness/in	dustry
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$\leq$	houl d Me mark	ပ္	19a. Informant's Name/Relations		801	19h Mailir	ng Address (Stre					Ot-t- T	
Maryland	d2s than 7 is trau		Ralph Higgs/s				Potoma						
	1 and 2 Health sm 27 i		20a. Method of Disposition		20h		sition (Name of	Aven		Date			
ō	it of its or o		1 ☐ Burial 2 ☐ Cremation	3 Removal from		cemetery, crei	natory or other p	lace)		Jale	ZUC. LOCA	tion - City or To	own, State
.≣	tmer tant:		4 Donation 5 ☐ Other (S		7			- !					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service RONALO	S. Wade, I	recto	r St	Name and Add	ress of Facili Comy	oard	655 W.	Balt	imore 9	Street
	40 = 60	-	- tony	100	uer	Ba	altimore	, MD	2120	1			
m			2 a. Part Enter the disease, o shoo or heart failure. List	r complications that c t only one cause on e	aused the dea ach line.	th. Do not ent	er the mode of d	ying, such as	cardiac o	or respiratory ar	est,		Approximate Interval Between
	Physician		Immediate see (Final disease or condition	SUB	-avac	innoi	d Hen	mah	LASE				Onset and Death
	/Medical		resulting in death)	Due to (	or as a consec	quence of):	d Hen		1				
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ó	exe an ar rial-t	EX	resulting in death) Last	Due to (	or as a consec	quence of):							
68760,	icate be executed physician and the burial-transit	dical		d									
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ŏ	h cer endin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			le				230	d. Date of delive	ery
m	deat d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	irth 2□Feta ant at time of c		lEctopic pregnar ] Other <i>(specify)</i>	icy				Month	Day Year
P.O. Box	t the	Physician/Me	9 □ Unknown	9□Unkno	wn								
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant condition	ons contributing to de	ath but not res	sulting in the ur	nderlying cause g	iven in Part I		23e. Did to	bacco use	contribute to the	ne cause of death?
Records,	quire n sig	d b								1 □ Y	es 2	No 3□Prot	ably 4 Unknown
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æ	he lav e has	m								autop	y med?	prior to condeath?	psy findings available mpletion of cause of
g	iclan: Th certificate rector, pag		25 Mas asso referred to redice	,						1□ Yes	2 1 1/0	1 ☐ Yes	2 □ No
Vita		Be	25. Was case referred to medica examiner?	Hospital:	/			thor		(Check only or			
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L C	ding I. After funer	io l	1 Natural 5 □ Pendin	ig (Mont	h, Day Year)	Injury	28c. Inj W			28d. Describe h	ow injury o	ccurred	
S	or Attending after death. Director: After in by the funer	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be	of inium. At h			]Yes 2□					
2	or A fiter ( Direct in by	ŧ	4 ☐ Homicide determ	lined buildir	ng, etc. <i>(Special</i>	ome, iarm, stre fy)	et, factory, office	•	2	28f. Location (S: City or Tow	reet and N n, State)	lumber or Rura	l Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifyir (Check only one) 2 ☐ Medical	ng Physician: To the Examiner: On the ba	isis of examina	owiedge, death ation and/or inv	occurred at the estigation, in my	time, date ar opinion, dea	nd place, a ath occurr	and due to the c ed at the time, c	ause(s) an ate and pl	id manner as s ace, and due to	tated. the cause(s)
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	Z × Z		, ,					nse number		2	ad. Date s	igned (Month,	Day, Year)
}			June Ce	Decembr	)			061	117		Jani	MARY 9	14, 2007
			30. Name and address of person			n 23a) (Type, I		E. 1	mt.	etan	55	5	
			trancisco A	Daniel			Hac	52131	m,	MD:	2174	10	
	Sta Registra	-	31. Date filed (Month, Day, Year)	2007	egistrar's Signa	y.	all s						

			State of Maryland / Department of Health and Mental Hyg	giene
				Reg. No. 007 01090
	Physici			Day Year 3. Time of Death
	/Medic Examin			4c. County of Death
			Charylane Nivering Centor Larrel MD	PG.
	Funeral		5. Social Security Number 6. Sex 1 M M 2 F 7. Age (In yrs. last birthday) 1 Vrs.  1 M M Norths Days Hours Min. (Month, Day) 1 M M Norths Days Hours Min. (Month, Day)	
	Director		Usual Residence of Decedent	18 Pennsylvania
	arylan show	Ŀ	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	the M.	Director	10e. Street and Number 10f. Zio Code	1 ☐ Yes 2 € No
	3e or	I Dir	6336 Color lane 21844.	USA
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White etc.
36	d within 72 hours after death with the Maryland jene. Ir then "neturel", or Items 23e or 28e-f show It is Medical Examinat must be notified at	by Fu		Specify: white
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lary	S is all		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number)	r, City or Town, State, Zip Code)
	s 1 and if Health item 27 other tr		Sandra Leibson/niece 6300 Forest Mill Lane Laure1  20a. Method of Disposition Date	
Baltimore,	permit. Pages. Department of h Important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☒ Donation 5 ☐ Other (Specify)	20c. Location - City or Town, State
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee Round S. Wade Piractor State Anatomy Board 655 W. Baltimore, MD 21201	Baltimore Street
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an shock, of heart failure. List only one cause on each line.	Interval Between
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	p is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	10:190
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ord	w requires that s been signed b should be det			es 2 ☑No 3 ☐ Probably 4 ☐Unknown
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/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 26. Place of Death /Check only or	ne)
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ion	Attending r death. ector: After by the fune	atlor	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 2 Accident investigation 28b. Time of 28c. Injury at 28d. Describe h	on inquity occurred
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	To the Hospital or Attending Physician: within 24 hours atter death and 17 to the Funerel Director: After this certifical completely filled in by the funeral director,	edical C		ause(s) and manner as stated. late and place, and due to the cause(s)
	To th To th comp	Me		29d. Date signed (Month, Day, Year)
ł			N41978	1-8-2007
			30. Note and address of person who completed cause of death (Item 23a) (Type, Print)  Nade lavakoh: 4000 Millandille Ad A?	1-8-200/ 12 BOWIE MA
	<sub>a</sub> Sta	te	Of Date (Hard March Day March ) Of Dariety de Olivert	207/6
	Registr	ar	IAN 1 9 2007 Reaves & Spartis	

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			1. Decedent's Name (First, i	Aiddle, La	ast)							2. Date of De	ath Day		Van	3. Time of De	ath
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)	Examir		4a. Facility Name (If not inst			iber)		4b. City,	Town, o	Location (	of Death	197	4c.	County	of Death		
			7027 Dawson							ston				Caro	line	2	
	Funeral		5. Social Security Number	1	Sex 1 ☐ M 2 🂢 F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June 4	th y, Year)	0.1	Cou		reigr
	Director		150-20-6631 Usual Residence of Decede			85						June 4	, 19.	21	Mich	igan	
	/land		10a. State 10b. Co			10c. Ci	ty, Town or Lo	cation								10d. Inside City L	imits
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	or 28,	Director	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of W	hat Cou	ntry?	
	th will	ai	7027 Dawson	Brar	nch Drive	3				2165	55			USA			
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	1 and Health em 27 ther tr		Bonnie Hend	CICKS	s/sister					tree		maus, P					
Baltimore,	Pages 1 ment of H tent: If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☒ Donation 5 ☐ Oth	er (Speci	ify)		Place of Dispo cemetery, crei	sition (Nam natory or o	ne of ther plac	e)		Date	20c. Lo	cation - (	City or T	own, State	
Ball	permit. Page Department of Important: If any injury or ance.		21. Signature of Funeral Services	S.	Wade D	irecto	r Si	Name and ate A	d Addres Anat ore,	omy B	v oard 2120	1 <sup>655</sup> W.	Ba1	.timc	ore S	Street	
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Division o	After After fune	Certification;	2 ☐ Accident in	ending vestigation	on	n, Day Year)	28b. Time of Injury	М		/at ⟨? Yes 2 ☐		28d. Describe l	how injury	/ occurre	ed		
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	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edicai	29a. Certifier 1 NCer (Check only 2 Med one)	tifying P lical Exa	hysician: To the minar: On the ba and mann	sis of examina	owledge, death ation and/or in	occurred a restigation,	at the tim in my op	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and man place, a	nner as s nd due to	tated. the cause(s)	
)	with To 1	Σ	29b. Signature and title of or	ertifier	Na	9/R	4	290	. License	51 V	39			e signed		Day, Year)	
			30. Name and address of pe	rson who	completed cause	of death (Item	n 23a) (Type,	Print)				-		<u>-</u>			
	Sta Registr		Karen Elizal 31. Date filed (Month, Day,			gistrar's Signa	ature La			,Md 2	21629	)				7.44	
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		-	For State Registrar		State of	Marylar		partme <i>ertifica</i>			ind M	ental Hyg	jiene	007		nın	92
el, "	Discourie!	_	1. Decedent's Name (First, Mic	idle, Last)	1 1	)						2. Date of Dea Month	- 11.00	Yea		3. Time of E	Death
	Physici /Medic		Kuth		Hu	CKE						Jau.	. //	1,200		6:35	Q.M
	Examin	er	4a. Facility Name (If not institut	-						Location o	f Death		4c. (	County of De	ath		
	<u>,                                     </u>		St. Elizabeth 5. Social Security Number	6. Sex		lome '. Age (In yrs.	last hirthda		1 <b>ti</b> mo	ore	24 Hrs.	8. Date of Birth		0.5	Righola	ce (State or	Fossian
	Funeral Director		282-01-1588		M 2∏F	95	Yrs.	Month		Hours	Min.	Month, Day Feb 20,	, Year)		Countr	y)	roreigir
1	<u> </u>		Usual Residence of Decedent							1		100 20,		ı ma			
	anylar	<u>_</u>	10a. State 10b. Cour	nty			ty, Town or								10	d. Inside City	
	28a-1	Directo	MD 10e, Street and Number			ва	ltimo:						0			1X Yes	
	ath with t		3320 Benson	Aven	ue			101. Z	(ip Code	21227			og. Citiz	USA	Counti	y?	
036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "naturel", or iteme 23a or 28a-f ehow do other then "naturel", or iteme 23a or 28a-f ehow event, the Madical Examiner must be notified at	by Funeral	11. Marital Status  1   Never Married 2   M  3   Widowed 4   Divorce	arried	2. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	es? ∑XINo	J.S. 1		edent of Hi ecify Cuba 2ሺ No	ispanic Orig in, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		4. Race - Ar Black, W Specify: To	hite, et	C.	
2-0	72 h	etec	15. Deced (Specify only hig	ent's Educ hest grade	ation completed)		16a. De	cedent's Us	ual Occupa	ation during most	of workin	ig .	16b. Kin	d of Busine	ss/Indu	istry	
2	vithin ne ne	Completed	Elementary/Secondary (0-12		College (1-	4or 5+)		ive kind of v e. DO NOT		)							
2	filed v Hygie other ti	ပိ	12 17. Father's Name (First, Midd	le (ast)	0		boc	kkeep	er	18 Mothe	r's Nama	(First, Middle,	-	nting			
and	b d la d	o Be	John Antor		re							eana Sp		,			
2	d 2 should the and Men 7 is marks traumatic	ပ	19a. Informant's Name/Relation				19b. Ma	ailing Addre	ss (Street a			Route Number			a. Zip C	Code)	
Z Z			Elizabeth Wa					_				7 Balti				227	
Baltimore, Maryland 21215-0036	of He ritan	l	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic 4 ☒ Donation 5 ☐ Other	n 3 □Re			Place of Dis	sposition (Nerematory of	ame of		and the same of			cation · City			
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Servi	y D.	Rleasa	no	ant			s of Facility Omy		1 655 W	Ва	ltimor	e S	Street	
	Physician physician and Medical Examiner street the private fransit street the private franchistics of the private franchist of the private franchistics of the private franchistics of the private fr	ical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or complicitionly only	Due to (c	used the dearth line.  Property as a consecutive as a con	quence of):	enter the m	ode of dyin	g, such as (	cardiac or	respiratory arr	est,		1	Approximate nterval Betw. Donset and De	
.O. Box 68	death certif e attending d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23		th 2 ☐ Feta int at time of o	al death	3⊟Ectopic 5⊟ Other (					2	3d. Date of o		/ ∂ay Y∈	aar
Records, P	es tha	ρ	Part If. Other significant cond	litions cont	inbuting to dea	ath but not res	sulting in the	e underlying	cause give	en in Part I.		23e. Did to				cause of de	
<u></u>	w require been si should I	lete	1des /	r Hi	1. 21	000	06 12	u				24a. Was a	ın	24b. Were	autops	sy findings av	/ailable
		Completed	Hylle 27	Thi	500	N						autops perfor 1  Yes	med? 2 No	prior t death 1 🗌 Y	?	pletion of cau	use of
Vital	Physician: r this certifice ral director, i	o Be	25. Wa say referred to med examiner? 1 ☐ Yes 2 █ No	_	ospital:		3.ED/0 ·		Oth			(Check only or	-		-		
ō		-	1 ☐ Yes 2 No 27. Manner of Death	-	28a. Date of	f Injury	ER/Outpa 28b. Time	e of	28c. fnjun Wor	4 Nu		8d. Describe h			oecify)		
o	Attending Fir death.	to	1. Naturaf 5 ☐ Per 2 ☐ Accident inve	ding stigation	(Month	i, Day Year)	Injur	У		k? Yes 2.⊟1	No						
Division of		Certification:	3 ☐ Suicide 6 ☐ Cot	ld not be ermined	28e. Pface of building	of Injury - At h g, etc. (Speci	nome, farm,	street, facto	ory, office		2	8f. Location (S City or Town			Rural	Route Numb	θΓ,
	To the Hospital or At within 24 hours effer of To the Funeral Directompletely filled in by	edical C	29a. Certifier 12 Certification (Check only 2 Medicone)	ying Phys al Exemin	icien: To the ler: On the ba	sis of examina	owledge, de ation and/o	eath occurre r investigation	ed at the time	ne, date and pinion, deal	d place, a th occurre	nd due to the cod at the time, d	ause(s) a ate and	and manner place, and d	as sta lue to t	ted. he cause(s)	
	To the H within 24 To the Fi complets	Me	29b. Signature and title of cert	ifier	//	7	11 -		9c. License					signed (Mo			
2			1	7/	/	- 1	W		25	27	46		Tare	1. 1	5	200	77
			30. Name and address of pers	pn	111.	72	m 23a) (Typ	pe, Print)	den	Ce	lesi	to La	an	e d	et	8212	25
	Sta Regista		31. Date filed (Month, Day, Ye	W/ 00	n 7	gistrar's Sign	M	Mar. W.									
DH	MH 17 Rev 1/2	001	JAN 1	3 (1)	UI JO	gistrar's Sign	18. J										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Year 2007 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, pr/Location of Deeth 4c. County of Deeth Examiner If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. **Funeral** Days 1□M 20 F Director Neu Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Directo more 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status nt Ever in U,S. Was Decedent Everage Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden and Mentel I 2 Peges 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vieado 20b. Place of Disposition (Name of cemetery, crematory or other place) , Date 12007 Dwings Mills, Md. 4 ☐ Donetion 5 ☐ Other (Specify) jarrison any injury 21. Signature of Funeral Service Licensee Joseph Enter the disease, or complications that cabed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) ACCIDENT a CEREBROVASCULAR Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 that initieted events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No RENAL FAILURE δ edical Certification: To Be Completed 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was en eutopsy performed? HYPERTENSION 1 DIABETES MELLITUS. 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 A Natural 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined within 24 hours efter de To the Funeral Directo completely filled in by th Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUARY )4みてみ3 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 5310 OLD COURT ROAD HYVERAHALU HARISH RANDALLATOWN 1010 21133 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar DHMH 16 Rev 6/95

			for State Registrar	State	of Maryla	and / Dep <i>Ce</i>	artmen <i>rtificat</i>				lental F	Hygie Reg.	21111	010	95
			1. Decedent's Name (First, Mide	dle, Last)						·	2. Date of	Death	D- V	3. Time o	f Death
	Physici /Medi		Mary A. Hork	(a							Janua:	rv 1	7, 2007	2:00	РМ
1	Examir		4a. Facility Name (If not institution	on, give street and n	umber)		4b. City,	Town, or	Location				4c. County of Dea		
			Stella Maris				Timor	าำเเต					Baltimor	e	
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under	1 Year	If Under		8. Date of	Birth	9. Bir	thplace (State	or Foreign
Ю	Director		240-10-3435	1□ M 2□F	92	Yrs.	Months	Days	Hours	Min.	Apr.	Day, Ye 16,	1914 Nor	ountry) th Caro	lina
	2		Usual Residence of Decedent												
	how	_	10a. State 10b. Count	у	10c.	City, Town or Lo	ocation							10d. Inside C	
	e Ma	5	MD N/A		Ва	ltimore								1 Yes	2 🗌 No
	1 th	<u>re</u>	10e. Street and Number				10f. Zip	Code				10g.	. Citizen of What C	ountry?	
	23a	a	1337 Pentridge	e Road			21 23	39					USA		
	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if health and Menial Hygiene. Item 27 ie marked other than "nature!, or iteme 23a or 28a-f show other treumatic event, its Medical Examinar must be notified at	by Funeral Director	11. Marital Status		cedent Ever in	U.S. 13.	Was Deced	dent of Hi	spanic Or	rigin? (Spe	ecify Yes or	No-	14. Race - Am		
9	or ite	E	1 ☐ Never Married 2 ☐ Ma	rried 1 TYes	2 [].No						Rican, etc.)		Black, Whi	te, etc.	
8	ours E	ğ	3 XWidowed 4 ☐ Divorce	d If Yes, G Year or	Dates:		1 🗆 Yes	ZIAI NO	Specify:	:			Specify:	white	
21215-0036	2 should be filed within 72 hours after dee and Mental Hygiene. Ie marked other than "naturel", or iteme 'eumaite event, it a Medical Examinar m	Completed		nt's Education est grade completed	0	16a. Dece	dent's Usua	al Occupa	ition	et of work	20	161	b. Kind of Business	/Industry	
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2	gian di	Ö	12			Homema	aker					0	lwn Home		
B	e filed al Hygie I other vent, u	Be (	17. Father's Name (First, Middle	, Last)					18. Moth	er's Name	(First, Mid	dle, Mai	iden Sumame)		
Maryland	ouid be Mental Marked o	To	Felix Sondey						Eva	Suda	hl				
ary	shot and a	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address	(Street a				mber, C	ity or Town, State,	Zip Code)	
	and 2 ealth a n 27 io		Anthony Horka	/ =	on	7023	lamai	r Tra	ail.	Flor	ence	мт	59833		
Baltimore,	ss 1 and 2 of Health item 27 i	11.3	20a. Method of Disposition	/		. Place of Dispo	sition (Nan	ne of			Date .		c. Location - City or	Town, State	
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三	permit. Pages 1 Department of H Importent: if Ite any injury or ot		4 Donation 6 Other (		l Ni	ew Cath	edral 2. Name an			1/22	/07		ltimore,		
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1	/Medical		resulting in death)	Due to	(or as a cons				, 50/1	119				1	_
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m	leath atte	cla	in the past 12 months?		birth 2 □ Fo nant at time o		Ectopic pro Other (sp.						Month		Year
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ه م	that ed by data		Part II. Other significant condit	ions contributing to	death but not r	esulting in the u	nderlying ca	ause nive	n in Part I	 I	23e D	id tobac	co use contribute t	o the cause of	death?
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Records,	e iaw has b je 2 s	Completed									24a. W	as an atopsy	24b. Were a	utopsy findings completion of a	available
<u> </u>	The The page	lo No									pe 1∐ Ye	erformed	d? death?	2 □ No	
Vital	Attending Physician: Thr r death. ector: After this certificate by the funeral director, pag	0	25. Was case referred to medica	al					26. Place	e of Death	(Check on		7.01		
<b>&gt;</b>	ysic is ce direc	ToB	examiner? 1 ☐ Yes 2 ⊠No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3□ DO	A Othe	·				e 6 □Other (Spe	acifu)	
o o	g Ph erth eral		27. Manner of Death	28a. Date	of Injury	28b. Time o	2	8c. Injury Work					injury occurred	,/	
Division	nding F th. :: After e funer	150	1 ⊠Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Moi igation	nth, Day Year)	Injury	М		es 2 🗌	No					
N.	i or Attendi aftar death. Director: A d in by the fu	5	3 ☐ Suicide 6 ☐ Could	not be 28e. Ptac	e of Injury - At	home, farm, str	eet, factory	office		- 12	28f. Locatio	n (Stree	t and Number or R	ural Route Nun	nber.
Š	afta Dir	Certification:	4 Homicide	build	ding, etc. (Spe	cify)					City or	Town, S	State)		
	To the Hospital or Atter within 24 hours after de To the Funeral Direct completely filled in by th		29a. Certifier 12 Cartifyi	ng Physician: To th	e hest of my k	nowledge deat	a occurred :	at the tim	e date an	nd place of	and due to t	he caus	n(a) and manner a	n ntetd	
	Fur Fur stely	Medical	(Check only 2 Medical one)	l <b>Examinar</b> : On the l	basis of exami	nation and/or in	vestigation,	in my op	inion, dea	ath occurre	ed at the tim	ne caus ne, date	and place, and du	s stated. B to the cause(:	s)
	thin the	Me	29b. Signature and title of certific		THE Stated.		290	License	number			:104	Date signed (Mon	th Day Year	
	F 3 F 8		Signature of continu		V.	Lat MA	1	1		711		1	Date signed (Mon	/ O M	000
	4		- mest	ind A	Jud	ACI AM	)	1)	> <	14	0	7	anvary	11.0	Cut
	2		30. Name and address of person	who completed cau	ise of death (I	em 23a) (Type,	Print)						7.		
′			ERNESTINE WRI			DULANE	Y VALI	LEY I	ROAD	TIM	ONIUM	, MI	21093		
	Sta	te	31. Date filed (Month, Day, Year	32.1	Registrar's Sig		- 480								
	Registr	ar	JAN 1-9	2007	20.5 M	A Agen									

			1 - For State Registrar	State of I	Marylar				ealth a	and M		Rag. No.	007	01096	
	Physici	an	Decedent's Name (First, Middle, L	ast)							<ol><li>Date of De Month,</li></ol>	ath Day	Year	3. Time of Death	
	/Medic		Franz, J	, Har	16						JaN	12	200		
4	Examin	ier	4a. Facility Name (If not institution, g				4b. City	, Town, or	Location o		l	4c. (	County of Dea		
				d County Gen		spital last birthday)	If Unde	r 1 Year	If Under a		lumbia  8. Date of Bin	th .		Howard thplace (State or Foreign	_
	Funeral Director		217-16-3673	15 M 2 F		96 Yrs.	Months		Hours	Min.	(Month, Da	y, Year)	3.00	ountry)	
	ס		Usual Residence of Decedent								July 9	, <del>1910</del>		Maryland	_
	show	_	10a. State 10b. County		10c. Ci	ty. Town or Lo	cation							10d. Inside City Limits	
	8 -1.	Director		Howard					Ilicott C	ity	·			1 ☐ Yes 2 No	_
	With th	Dire	10e. Street and Number				10f. Zi	p Code	24	040		10g. Citiz	en of What C	,	
	9ath v	Funeral	8922 Wilton Ave.	12. Was Decede	nt Ever in II	18 13 1	Mac Deco	dont of Hi		043	wifu Vac or No	_ 1	4. Race - Am	J.S.A.	
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036	ors a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	7		1 🗌 Yes	2 0 No	Specify:				Specify:	White	
21215-0036	72 hours after death with the Maryland naturel', or Iteme 23a or 28e-f show dical Examination notice incitied at	Completed	15. Decedent's (Specify only highest of			16a. Dece	dent's Usu	al Occupa	ation furing most	of worki	na	16b. Kin	d of Business	s/Industry	_
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Maryland	tal h	Be							ia. Mulile	i s Name			,		
Ž	should be ind Mental I is marked o	2	19a. Informant's Name/Relationship	lwig Hartig		19h Mailir	na Addres	s (Street a	and Numbe	r or Rura	I Route Numbe		Siegle	Zin Code)	_
Ma	end 2 s eelth an n 27 is.		Mrs. Jane Hartio		Vife						ty, Maryla			219 0000)	
e,	r Hee		20a. Method of Disppsition	-	20b. F	Place of Dispo cemetery, crer					ate		ation - City or	r Town, State	-
SE	Pages nent of int: If Its iry or o		1 ☐ Burial 2 🕏 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			County C			1	no 01/	15/2007		Svkesvil	lle, Maryland	
Baltimore,	그 원활공 .		21. Signature of Funeral Service Lic	11					s of Facility	10.			,	,	
m	Deperment Impo		Miladi	Hackert	DIKK			Slack I	Funeral	Home	e, P.A. Pike Ellico	tt City	MD 2104	13	
7	Physician /Medical Examiner		23a. Part1. Enter the disease, of co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	sed the death line.	iner	er the mo	de of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onser and Death	-
8760,	rate be executed only sicien and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	Due to (or as a consequence of):  Due to (or as a consequence of):										
87	physical phy	dlcai		d											= 1
.O. Box 6	The law requires that the death certificate be executed to has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transitions.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birtt 4□Pregnan	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown							2	blivery Day Year		
ls, P.	res ther igned to be det	þ	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	nderlying	cause give	en in Part I.					o the cause of death?	
9	w require been sign	eted	Coroney Are	my Class							-	Yes 2□	1N0 3 F	robably 4 Onknown	
of Vital Records,		Completed	general terms when the comment and	•							24a. Was autor perfo		24b. Were a prior to death?		_
<b>Vit</b>	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	,	1		Othe			(Check only o				-
ō	Physical distribution	5.	1 Yes 2 TeNo  27. Manner of Death	1 1200		28b. Time of		UA	4 🗆 140		ne 5 Resident			ecify)	-
on	ding th: Afte	育	1 Pending 2 Accident investigat	28a. Date of (Month,	Day Year)	Injury	м	28c. Injury Work 1 □ `							
Division	To the Hospital or Attending Ph within 24 hours after deeth. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	be 28e. Place of	M 1 ☐ Yes 2 ☐ No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					1	28f. Location (: City or To:		Number or A	lural Route Number.	
	Hospita 24 hours Funerel itely filler	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the basi aminer: On the basi and manner	s of examina	owledge death ation and/or in	n optimet vestigation	n, in my op	no date and pinion, deat	d duco r th occurre	and due to the ed at the time,	nausa(s) date and	and manner a place, and du	s stated e to the cause(s)	
	o the	Med	29b. Signature and title of certifier	and manife				c. License						th, Day, Year)	_
	⊢ ≤ ⊢ ŏ		NP//	M.D.			7	3D00	620	22					
	1		30. Name and person wh		of death (Iter	m 23a) (Type.	Print)								
	6		RAJIV DUA	8186 Lx	TRK	B/000	Rd	, ELL	2Ril	Re.	mb, zi	075	-		1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	istrar's Şign	ature	60	/		1					

			T- State of Maryland / Department of Health and Certificate of Death	_	ene . No. 2007	01097	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death	
me.	//Medic		Maracret D. Jones	1	18 07	08∞A M	
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat  Solic being  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1	8. Date of Birth	'ear)   Cou	place (State or Foreign	
4 (4	Alternative means	1	Usual Residence of Decedent	03/07/	1939   1	1D	
	arylan show dat	۰	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	he Ma 28a-f otiffe	ecto	MD Worcester Newark, MD	40.	011111111111111111111111111111111111111	1 ☐ Yes 2☐No XX	
	23a or	Funeral Director	10e. Street and Number 7614 Mulberry Road 2184	11	J. Citizen of What Cou USA		
936	be filed within 72 hours after death with the Maryland that Hyglene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Extender must be notified at		11. Marital Status  1 Never Married  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 No If Yes, specify Cuban, Mexican, Puer If Yes, Give Year or Dates:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify:		
2-0	72 hou natura dical E	sted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rkina 1	6b. Kind of Business/Ir	ndustry	
21215-0036	vithin ne. han "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	, and	Own	Home	
	filed v Hygie other t	OO @	12 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Nam	me (First, Middle, Ma			
lan	should be filed vind Mental Hygie marked other timarked other timarked ther timarked other timarked the timar	To Be	" - 1 - 1 1	et Carne			
Maryland (	nd 2 ulth a 27 is r trai		19a. Informant's Name/Relationship (Type. Print) Francis Jones / Husband 19b. Mailing Address (Street and Number or R. 7614 Mulberry Rd,			ip Code)	
Baltimore,	ges 1 al t of Hea if Item or othe		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20a. Method of Disposition (Name of cemetery, crematory or other place)		c. Location - City or T		
ţ	tment of tant: If It		4 □ Donation 5 □ Other (Specify)   Cedar Hill Cemetery 0	1/22/200	7 Baltim	ore MD	
Bal	permit. Page Department. Important: Il any injury o		21. Signature of Functal Service Licensee  Victor P. Doda, Jr. Charles L. Ste  1501 E. Fort A	ve. Balt	imore MD	, Inc. 21230	
창	4 %		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arres	t,	Approximate Interval Between Onset and Death	
6	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (assessed to the condition of the				
	Examiner		Due to (or as a consequence of):				
	T. V. #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter ungenying  Due to (or as a consequence of):				
	and A	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
58760,	ficate be executed physician and sthe burial-transit		Due to (or as a consequence of):				
_	ifficate g physas the	edical	ō.				
.O. Box	that the death certificed by the attending of the detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day		
Δ.	es je je	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fart I.	23e. Did toba	cco use contribute to	the cause of death?	
Records,	e law requii has been s je 2 should	Completed		24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of	
Vital	ician: The licertificate ha				No 1 ☐ Yes	2 No	
>	S S	o Be	examiner? Hospital: Other:		ce 6 ☐Other (Spec	ifv)	
n or		T: T	Total Control of the	28d. Describe how			
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be				
Division	al or At after d I Direc d in by	Certification:	4 ☐ Homicide determined determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C		e, and due to the cau curred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier  29c. License number  29c. License number	-	d. Date signed (Month	, Day, Year)	
	1				1 / 0	- /	
	ľ		David F. Coreall, MD Coastel 1-lospin Po Box	1733	Salus	10 2/802	
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature		Š		

07-00462 Everett H. Johnson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I - For State Registrar	ato or maryiana / 1	Certific	cate of	Death		.a. mygior	Ren	No OO	2.7
Physicia	n/	Decedent's Name (First, Middle	e,Last)						of Death	4.0	8. Time of Death
ledical Exami	ner	EVERETT HEANON	JOHNSON					Mon Jani	uary 16	Day Year , 2007	2347 hrs
		4a. Facility Name (if not institution			4	b. City, Town, or	r Location o	of Death		4c. County of E	
		Prince George's Hosp				Cheverly	F (6) 1	- 0411 To B	to of Blate	Prince Ge	
Funeral Director		5. Social Security Number		n yrs last bi	ппаау)	If Under 1 Year Months Day		Min		F	9. Birthplace (State or oreign
Director	-	212 62 2469	1 <b>X</b> M 2 F	53	Yrs.			02	<b>-04-</b> 1	L953	Country) NC
any	ŀ	Usual Residence of Decedent  10a State 10b. County	10	c. City, Towr	n or Locatio	on					10d Inside City Limits
ž		MD PRIN	ICE GEORGES	11101	PED M	ARLBORO					1 Yes 2 X No
Aaryland 28a-f show Latonce,	휭	10e. Street and Number	CL GLORGED	011	L EK FL	10f. Zip Code			100	Citizen of What	
he Ma	Director	4827 KING JOHN	HTCHWAY			26	0772			USA	,
with t	eral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was	Decedent of Hi		jin? ( Specify Ye	es or No-		American Indian, Black.
Jeath r iten	Fune	1 Never Married 2 X Ma	arried Armed Forces?  1 X Yes 2	No	If Ye	s, specify Cuba	n, Mexican,	Puerto Rican,	etc.)	White, e	etc.
after o	by F	3 Widowed 4 Div	orced If Yes, Give Year	, 140	1	Yes 2 X No	specify:			Specify:	BLACK
sours natura	eted t	15. Decedent's Education (Spec	cify only highest grade comple	eted) 16a.		s Usual Occupa			ne	16b. Kind of Busin	ess/industry
036 tthin 72 h ne r than "r ledical E	Set	Elementary/Secondary (0-12)	College (1-4 or 5+)		Ü	v	5. BO 1401	asc rearea)			
5-0036 iled within 7 Hygiene 1 other than	Comple	47. Enthuris Name (First Middle	1		PRIN	rer	10.11		1	PRIVA	ATE
15-00 filed wit al Hygien ed other t, the M	BeC	17. Father's Name (First, Middle, CLINTON S. JOH	•				18.Mother			aiden Surname)	
D 2121; should be fil and Mental F 7 is marked natic event, in	8	19a. Informant's Name/Relations		119	9b. Mailing	Address (Stre	et and Num	MARY W		er, City or Town,	State 7in Code)
S 22 C 21		GAIL JOHNSON/W		- 27							RO, MD 20772
e, M I and 2 Health item 2		20a Method of Disposition		20b. Place	of Disposit	tion (Name of ce		Date		20c. Location - Ci	
2 S G = 9		1 X Burial 2 Cremation 4 Donation 5 Other St	_		atory or oth	ON NATIO	ONAT	1/22/2	007	SUITLANI	) MD
Baltimore, permit. Pages I at Department of Hee Important: If ite		21 nature of Euneral Service		, 11101	22. Na	ame and Addres	s of Eacility	CUATT IC	EIINE	DOLLITARE	E OF MD, INC.
E E P & W		A. f. Tha	rshall			4308	B SUIT	TLAND R	D. SU	JITLAND,	MD 20746
Physician		2. Part I. Enter the disease, or failure. List only one cause		e death Do r	not enter th	e mode of dying	, such as ca	ardiac or respira	atory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a. Hypertensiv	e ather	oscler	otic card	iovascu	ular dise	ase		Death
The state of the s		or condition resulting in death)	Due to (or as a consequ	ience of):							
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	mine	cause Enter Underlying Cause (Disease or injury that initiated	c								
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760, icate be est physician the burial	/Medical	IF FEMALE:	#2,2 23c. If yes, outcome			G863, 1/2	.6/0/ T	Τ		23d. Date of de	livery
x 6876 h certificat tending phr use as the		23b. Was decedent pregnant in the past 12 months?	1 Live birth			al death 3	Ectopic	pregnancy		Month	Day Year
Box 68's death certification attending	siciar	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown									
that the dended by the	Phy	Part II. Other significant condit		ut not resulti	ina in the u	nderlying cause	given in Pa	art I. 23	Be. Did tob	acco use contribu	ite to the cause of death?
P.O.	þ	-	Ŭ		J	,	•	1			Probably 4 V Unknown
ords, w require ls been si	Completed							24	a. Was ar		re autopsy findings available
COL s law r e has b	g							—   <sub>-</sub>	autops: perform	ned? dea	
tal Rection: The certificate ector, page	ပိ	25. Was case referred to medica	al I			26 D) aa	o of Dooth	(Check only one	Yes 2	No 1 •	Yes 2 No
Division of Vital Records, is to Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the fine of the funeral director.	o Be	examiner?	Hospital,	2 🗸 ER/0	Outpatient		Other <sub>4</sub>	Nursing Home	<del>-</del>	Residence 6	Other
ing Phy After th funeral	-	27. Manner of Death	28a. Date of Injury		Time of Ir	njury 28c. Inj	ury at Work			ow injury occurred	
ion tendin eath. tor: A	ţi	1 X Natural 5 Pend		'		1	Yes 2	No			
ivision or Attendafter death Director:	ifica		stigation	y - At home	farm, stree	t, factory, office	building, et				or Rural Route Number, City
Divi	Certification:	4 Homicide dete	rmined (Specify)					or	Town, Sta	ate)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.			hysician: To the best of my k								
To the Hos within 24 h To the Fur	ledical		miner: On the basis of examir and manner stated	iation and/or	ınvestigati			curred at the tin	ne, date a		
	Σ	29b. Signature and title of certifie	er *				se number			-	(Month, Day, Year)
		mesc					.M.E.			January 17, 2	2007
75		30 Name and address of person Ana Rubio MD. Ass	n who completed cause of dea sistant Medical Examir			treet, Baltim	ore MD	21201			
	ate	31. Date filed (Month, Day, Year)			i ciii S	Dailiff	IOIG, IVID	-1201			
Regis		IAN T	8 2007	14	6	ante					
DHMH 17 Rev 1/2	001	DATE -	U 2001	0	RIGINAL	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Anna Cecelia Kasprzak 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BELAIRHEALTHAND Republication Center Har 01 If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Nov. 22,1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🗓 F Hours Min 87 Director Maryland 214-01-6219 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 66 Barrington Place 21014 U. S. Α. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify. 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other then 'iry or other treumatic event, Ite Ma Elementary/Secondary (0-12) College (1-4or 5+) Gift Wrapper 11th Grade Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) Be Michael Hepner Theresa Barszcz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Bradley (Dghtr) 66 Barrington Place, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department o Important: If any Injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cem. | 01/18/ 2007 Baltimore, Maryland 21. Signature of Funeral S vice Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc., 610 W. Macphail Rd., Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death S WILK Immediate Cause (Final disease or condition resulting in death) Culitis SCHIMIC Physician WECKS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and the dor use as a second Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/2/1 1□ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only order Other: 4 2 No Hospital: 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 □ Residence 6 □Other (Specify) 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28d. Describe how injury occurred Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funerel DI completely filled in 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

death.

with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

10

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

and manner stated.

			1 - For State Registrar	· ·	partment of Health and Me ertificate of Death	ental Hygier	2007 01100
ı	Physici	an	Decedent's Name (First, Middle, Last)  T 0 '				3. Time of Death
	/Medic	al	Elizabeth B. Kuts  4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death		4, 2007 4:00 A M
	Examin	er	Manor Care Nursing Ce		Towson		Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 W	7. Age (In yrs. last birthday	/ If Under 1 Year If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yes Dec. 30,	ar) 9. Birthplace (State or Foreign Country) 1909 Maryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Mary a-f sh	tor	Maryland Baltimore		Parkville		1 ☐ Yes 2 <b>X</b> No
	or 284	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	e 23a	rall	8810 Walther Blvd.,		21234		U.S.A.
336	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "naturel", or lieme 23e or 28e-f show event, the Medical Examinat must be notified at	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. d Forces?  (es 2 No s, Give or Dates:	. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes 2 No Specify:	eify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade comple	16a. Dec	edent's Usual Occupation  a kind of work done during most of workin	16b	. Kind of Business/Industry
121	within ene.	mple	Elementary/Secondary (0-12) Colle-	00 (1-40r 5+)	e kind of work done during most of workin DO NOT use retired) L WLAPPEL		Supermarket
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	mea	18. Mother's Name	(First, Middle, Maid	
lan	should be nd Mental marked c	To Be	Frederick Davidson			th Kell	
Maryland 21215-0036	ges 1 and 2 should it of Health and Men it item 27 is marke or other treumatic		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and Number or Rural		
e, z	1 and 1ealth sm 27 ther tr		Marlene Dietrich (da 20a. Method of Disposition				Parkville, MD 21234  Location - City or Town, State
nor	Pages nent of l ant: If ite		1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal f  4 ☐ Donation 5 ☐ Other (Specify)		position (Name of peratory or other place)  0 & Faith Cem. 1/17/		· · · · · · · · · · · · · · · · · · ·
Baltimore,	permit. Page Department importent: Il any injury o		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Schi	munek Fur	ieral Homes
	0 D ≥ € Ø		23a. Part1. Enter the disease, or complications to		9705 Belair Rd., Ba		
	Pnysician /Medical		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	i CL	respiratory arrest,	Approximate Interval Between Onset and Death
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4	be executed sician and burial-transit	Examine	triat initiated events				
8760,4	ate be exe hysician a the burial-	cal Ex	d.	e to (or as a consequence of):			
9	ortificate ing phys e as the	Medi	IF FEMALE:				
.O. Box	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
<u>а</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
Vital Records,		Completed				24a. Was an autopsy performed	
Vita	sicien: " certifica irector, p	o Be	25. Was case referred to medical examiner?  Hospital:	4 Classical AC 500	26. Place of Death Other: 497 Nursing Hom		
of	nding Phys th. : After this s funeral di	$\vdash$	27. Manner of Death 28a. D	1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury Month, Day Year) 28b. Time Injury	of 28c. Injury at 28	e 5 ☐ Residence 3d. Describe how in	o 6 ⊡Other (Specify)  njury occurred
Division	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be	Place of Injury - At home, farm, s puilding, etc. (Specify)	treet, factory, office	Bf. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	Hospi     24 hour     Funer     Funer     Istely fills	edical	(Check only 2 Medical Examiner: On t	o the best of my knowledge, dea he basis of examination and/or i manner stated.	ath occurred at the time, date and place, ar investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier	1. 0	29c. License number		Date signed (Month, Day, Year)
)			e groc	Ch' DO.	H005442	4 1	-15-07
	3		30. Name and address of person who completed Cyrus Asadi, 20 E.	Timonium so	a. Print) I. Suite #209 Tim	onium	,MD 21093
	Sta Registi			Registrar's Signature	ander		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 23:30 PM Hnn ANUARY 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore
If Under 24 Hrs.

Alin Nlemorial lhion 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, June 19, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 68 Months Days 220-34-5080 Usual Residence of Decedent 1 M 2 F Yrs. Director the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow MD Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other then "naturel", or iteme 23a or vent, the Madical Examiner must be a West 2121 IJSA by Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Koland Elementary/Secondary (0-12) College (1-4or 5+) ticiar View lowers 18. Mother's Name (First, Middle, Maiden Surname) To Be avors nen 49a. Informant's Name/Relationship (Ty...., Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Health menevieve 20a. Method of Disposition Date 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Freen Moun Jan. 19,2007 21. Signal re of Funeral Service Licens permit.
Deporte
Imports
any nlt Funeral Services llstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** INFARCTION dAYS /Medical Due to (or as a consequence of): Examiner HYPERTENSION

Due to (or as a consequence of): 1-ARCS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physicien: The law requires that the death certificate be executed physicien and the burial-transit 10 YEARS DIADETES resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 ☐ No been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Tes 2 No I Director: A 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the bast of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760, within 24 hours e To the Funeral I To the Hospital

State Registrar

PARKWAY UniVERSITY

AT2438946

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 15, 2007

completed cause of death (Item 23a) (Type, Print)

UNION MEMORIAL HOSPITAL BALTIMORE, MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier Jennifer

32. Registrar's Signature JAN 19

Noznitsky

NANCY KEYSER Records. Division or Vital

> State Registrar

29a. Certifier (Check only

29b. Signature and tle of certifier

TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

				artment of Health and Me		ene2007 0110	3					
ı	Physici		1. Decedent's Name (First, Middle, Last)  ADD V KELLER		2. Date of Death  Month	Day Year 7 447	a					
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  MERCY MOSPITAL	4b. City, Town, or Location of Death	-	4c. County of Death						
	Funeral Director		5. Social Security Number  195-32-3164  6. Sex 1 ☑ M 2 ☐ F  64 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Y) Dec 31,	9. Birthplace (State or Foreit Country) unk						
	aryland show	_	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or L   MD   Raltim			10d. Inside City Limit						
	28a-1	recto	MD Baltim  10e. Street and Number	Ore 10f. Zip Code	100	Citizen of What Country?						
	h with	i D	501 W. Franklin Street	21201		USA						
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!, or items 23s or 28s-f show says injury or other traumatic svent, its Medical Examinant must be untilled at QRCs.	by Funeral Director	11. Marital Status unk  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.Sink Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☒ No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
21215-0036	within 72 ho ane. than "natur is Medical	Completed	(Specify only highest grade completed) (Give life.	dent's Usual Occupation Is kind of work done during most of working DO NOT use retired)	kind of work done during most of working							
Maryland 2	uld be filed to the filed the fental Hygierked other file svant, the file svan	To Be Co	unk unk  17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (	First, Middle, Ma	id <b>e</b> n Surname)	unk					
lary	2 shou and N is mai		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural	Route Number, C	City or Town, State, Zip Code)						
altimore, N	Pages 1 and 2 ent of Health ant: if item 27 in ty or other tra	,	20a. Method of Disposition 20b. Place of Disp	St. Paul Place Balt osition (Name of matory or other place)	7	MD 21202 c. Location - City or Town, State						
Balti	permit. Depertm Depertm Importar any Injur		21. Signature of Funeral S. Wade, iregtor S. Wade,	2. Name and Address of Facility tate Anatomy Board altimore, MD 21201	655 W. I	Baltimore Street						
}	Physician /Medical		resulting in death)	ter the mode of dying, such as cardiac or		Approximate Interval Between Onset and Death						
	ate be executed hysicien and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  CARCHAL ARCEST  Due to (or as a consequence of):  CARCHAL ARCEST  Due to (or as a consequence of):  CARCHAL ARCEST  Due to (or as a consequence of):  CARCHAL ARCEST  Due to (or as a consequence of):  d.									
P.O. Box 6	death	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown		23d. Date of delivery  Month Day Year							
	law requires that the es been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		cco use contribute to the cause of death?	₩n					
al Reco	The ste h page	Completed			24a. Was an autopsy performe		ole of					
Vita	tician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (								
Division of Vital Records,	Attending Physician: r death. sctor: After this certifice by the funeral director.	ation: To	1	AL SO DOA 4 Nursing Home	e 5 ☐ Residend ld. Describe how	ee 6 □Other (Specify) injury occurred						
Divis	5 # E	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	If. Location (Stree City or Town, S	et and Number or Rural Route Number, State)						
	To the Hospital within 24 hours e To the Funeral Completely filled	Medical	29a. Certifier (Check only one)  t □ Certifying Physician: To the best of my knowledge, deal 2 □ Medicaf Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an exestigation, in my opinion, death occurred	d due to the caus d at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)						
	To the within 2 To the complete	Σ	29b. Signature and title of certifier Cost, MD	29c License number D42C3	4 290	Date signed (Month, Day, Year)  5, 200 7						
			30. Name and address of person who completed cause of death (Item 23a) (Type,	PINT) PLACE BA	47/10	RE, MD 2120:	2					
Æ	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	reali								

			For State	State of Ma	aryland	-	artment of H		Mental Hy	giene	0 7	01101	
			1 - State Registrar	0		Cei	rtificate of I	Death	10000	Reg. No.	U/	UIIU4	
	Physici	an	1. Decedent's Name (First, Middle, I	11 1.					2. Date of De Month				
	/Medic		4a. Fagility Name (If not institution, g	Listia ive street and number)	nser	1	4b. City, Town, or	Location of Dea	th (	4c. County of Death			
	Examin	er		pital Co	ator	n.	lalacta	inche /	-		Co co	0(1	
136	Funeral	1		Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs		rth	9. Birthr	place (State or Foreign	
<u>a</u>	Director		216-32-1091	1□ M 2 💢 F	78	Yrs.	Months Days	Hours Min	Apr 4,	1928	Fran		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation					10d. Inside City Limits	
	Maryla f sho ed at	5	MD Carrol	1	,,,		sville					1 ☐ Yes 2 No	
	the 28a-	rect	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntrv?	
	3a or	O E	7309 2nd Avenue					21784		USA		,	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No	o- 14. Ra	ce - Americ		
9	after or ite		1 Never Married 2 Married	1 ☐ Yes 2 🛣	No	1	1 □ Yes 2 🎞 No	Specify:	no nican, etc.)		ack, White, ify: <b>whit</b>		
21215-0036	hours ural";	d by	3 Widowed 4 Divorced	Year or Dates:									
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ılar	should be nd Mental marked o	To B											
Maryland	and and sum	,	19a. Informant's Name/Relationship	(Type. Print)	- 1	19b. Mailir	ng Address (Street	and Number or A	ural Route Numb	er, City or Town	ı, State, Ziç	Code)	
	C = 6/ F		Ann Marie Napier	/daughter			Oakleigh	Drive		er, MD	2110	2	
Baltimore,	8 5 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Plac	ce of Dispo netery, crei	sition (Name of matory or other plac	e)	Date	20c. Location	- City or To	own, State	
tim	permit. Page Department of Important: If any Injury or once.		4 ☑ Donation 5 ☐ Other (Special Control of	-								_	
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic Anthony I	Pleasant	ent	-   <sup>2</sup> 6	Name and Addres State Ana Baltimore	tomy Boa , MD 21	rd 655 V 201	V. Balti	more	Street	
r Joseph			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	the death.	Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Myo	cardi	al	Infanto	200			1	Onset and Death	
	/Medical Examiner		resulting in death)	Due to for as	a consequer	nce of):	= 0					249	
	n what	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Vina	ry (	recent.	Latect	100			/	Days	
-	nsit	nine	cause. Enter Underlying Cause (Disease or injury that initiated events	1000	a conseque	(1.					1	0_	
Ć.	execu n and ial-tra	Examine	resulting in death) Last	C. Due to (or as	a consequer	nce of):				- ray c			
68760,	cate be executed physician and the burial-transit	dical		o. End	locar	diff	9			Days			
89			IF FEMALE:									//	
Box	death certifi e attending p id for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth			Ectopic pregnancy				ate of delive	,	
0	0 0 0	Physician/M	1 Yes 2 No	4□Pregnant at 9□Unknown	time of dea	th 5□	Other (specify)			M	onth	Day Year	
<b>a</b>	that the de led by the a detached		Part II. Other significant conditions	contributing to death b	ut not resulti	na in the u	nderlying cause give	en in Part I	23e. Did t	obacco use con	tribute to th	he cause of death?	
or Vital Records,	8 16 9	d by		J			, g g		10			pably 4 Unknown	
S	w require been si	lete							24a. Was	an 24h	More oute	ancy findings available	
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ta		Be C	25. Was case referred to medical	1				26 Place of De	1□ Yes ath Check onl	2⊿No	1 □ Yes	2 □ No	
r <	S S F	.0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 inpatie	ent 2∐EP	?/Outpatien	t 3 DOA Othe	)r.	dome 5 ☐ Resi		her (Specif	iv)	
0 0		i.i.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 21 y Year)	8b. Time of Injury	28c. Injury Work			how injury occur		,,,	
Sio		catic	2 ☐ Accident investigati					Yes 2 □ No					
Division	or Attending after death, Director: After in by the fune	Certification:	4 Homicide determine		ury - At home c. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location (a City or Tou	Street and Numi wn, State)	ber or Rura	al Route Number,	
ш	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying I	Physician: To the best	of my knowle	edge, death	occurred at the time	ne, date and plac	e, and due to the	cause(s) and m	anner as s	tated	
	e Ho: 124 h e Fur	edical	(Check only 2 ■ Medical Exone)	aminer: On the basis of and manner sta	t examination	n and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and place,	and due to	the cause(s)	
	To the Hy within 24 To the Forth complete	Me	29b. Signature and title of certifier	- 7	-		29c. License			29d. Date signe	d (Month,	Day, Year)	
			With	46 mo	)		000	5813	,7	1/14	67		
			30. Name and address of person wh	o completed cause of d	eath (Item 23	3a) (Type,	Print)	/	nster i		2 /		
			21 Data filed Month Day Your	245 Sto	ner /	tue?	+307	Woston	nster ,	MD C	115	/	
	Sta Registr		JAN 1 9 2	007 Heres	J. J.	do	ale y						
						17							

			1 - For State Registrar	State of Ma		artment of l rtificate of		Mental Hy	/giené/ Reg. No.	007	0110		
8	Physic /Medi		Decedent's Name (First, Middle, Last)     PATRICK BERNARI	O KIRWAN				2. Date of D Month JANUAF	Day	2007	3. Time of Death 10:20 P		
	Exami		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Dea	ath					
		\$2- -	8726 OAKLEIGH ROAL				VILLE		BALTIMORE				
4	Funeral Director		218-28-9890	мопг	(In yrs. last birthday 75 Yrs.	Months Days			rth lay, Yea <i>r)</i> 1932	9. Birthp Coun MAR	olace (State or Forei ntry) YLAND		
	aryland show dat	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limit		
	Ra-f	ecto	MD BALTIMORI	Ē	PARKVII								
	with the	Ë	10e. Street and Number			10f. Zip Code	100/			en of What Coun	itry?		
	eath v	eral	8726 OAKLEIGH ROAI		or in II S 12		1234	(Specify Vec or N		USA 4. Race - Americ	an Indian		
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	Was Decedent Every Armed Forces?     T □ Yes 2    Note of Yes, Give Year or Dates:	)	Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 【No		erto Rican, etc.)		Black, White,			
5-0	72 ho natur dical	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of w	orkina	16b. Kind	d of Business/Inc	dustry		
21215-0036	ed within ygiene. er than "	Completed by	Elementary/Secondary (0-12) 4-			E OF MAI	RYLAND						
Maryland	S should be filed withi and Mental Hygiene. Is marked other than aumatic event, the M	To Be	17. Father's Name (First, Middle, Last)  PATRICK B. KIRWA				BAR	ame (First, Middle BARA BAK	ER				
, Mar	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationship (Type DOLORES L. KIRWAN,		8726	OAKLEIG	H ROAD		al Route Number, City or Town, State, Zip Code) ALTIMORE, MD 21234				
Baltimore,	Pages 1 tent of Hant: If iten		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disp cemetery, cre METRO CF	osition (Name of ematory or other pla REMATORY,		Date 19/2007	İ	NSVILLE	, -		
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		21. Signature of Funeral Service License	•	·	2. Name and Addr 3521 LOCH			SON F	UNERAL I	HOME, P.A		
*	Physician /Medical Examiner	J.	23a. 25nl. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a		ster the mode of dy		ac or respiratory	arrest,		Approximate Interval Between Onset and Death		
38760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.										
P.O. Box 6	the death certific y the attending pl iched for use as f	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day		•							
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or Vital Records,	The law cate has the page 2 s	Completed						24a. Was auto perf 1 Yes		24b. Were autop prior to con death? 1 \( \text{Yes} \)	psy findings availab npletion of cause of 2□ No		
Vit.	lclan certifi ector	Be	25. Was case referred to medical examiner?	ospital:		T <sub>O+</sub>	hor	eath (Check only					
o	Phys r this ral dii	: To	1 Yes 2 No □	28a. Date of Injury		III JUDOA	4 🗆 Nursing	Home 5 Res			y)		
Division	ttending death. tor: After the fune	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Sulcide 6 ☐ Could not be	(Month, Day	Year) Injury	M 1□	Yes 2 No				. De table ale		
Div	ital or A urs after o rai Direc iled in by		4 ☐ Homicide determined	building, etc.			<u></u>	City or To	iwn, State)		l Route Number,		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of er: On the basis of e and manner state	examination and/or in	nvestigation, in my	opinion, death oc	ce, and due to the curred at the time	, date and p	place, and due to	the cause(s)		
	Voit Con	2	29b. Signature and title of certifier		~	29c. Licen				signed (Month, I	Day, Year)		
	115		Mevreu Ken  30. Name and address of person who con		ath (Item 23a) (Type,	Print)	7/027		1-	16-67			
	15		M. Koux Lous/a MD	7602 B	outin ne	X SACTO	J.M.D. 2	1236					
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar									

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

		1	For State Registrar	State of	Marylan		artment of I tificate of				iene <sub>eg. No</sub> 2 ()	07	01106	
	Diversità		1. Decedent's Name (First, Middle, La						2.	Date of Deat Month	h Day	Year	3. Time of Death	
	Physicia /Medic	al -	Andre							Januar	·	2007	4:10 A <sup>M</sup>	
1	Examin		4a. Facility Name (If not institution, give		oer)		4b. City, Town,				4c. County of Death  Montgomery			
			Manor Care Bet  5. Social Security Number 6.5		Age (In yrs.	last hirthday)	If Under 1 Year	hesd		Date of Birth			place (State or Foreign	
	Funeral Director		, , , , , , , , , , , , , , , , , , , ,	1 X M 2 □ F	85	Yrs.	Months Days		s Min.	(Month, Day,	Year) 10, 1921	New	Jersey	
			Usual Residence of Decedent											
	nylan show	_	10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	Ba-f	Sch	Maryland Montgo	mery	В	ethesd				1	0g. Citizen of	f Mihat Car		
	with the	Dir	10e. Street and Number 11706 Milbern Dr	daro			10f. Zip Code	854			United		-	
	eath	erai	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.	Was Decedent of	Hispanic	Origin? (Specif	y Yes or No-	14. Ra	ace - Amer	ican Indian,	
21215-0036	be filed within 72 hours after death with the Maryland nat Hyglene. ed other then "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 M Yes 2 If Yes, Give Year or Dat	es? !□No WW]		lf Yes, specify Cul 1 ☐ Yes 2 💢 No	oan, Mexi	can, Puerto Ric	an, etc.)		ack, White		
2-0	72 ho natur lical	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usual Occu	during n	nost of working		16b. Kind of	Business/li	ndustry	
2	ithin ne.	du	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retire	ed)			Fodore	1 Cox	vernment	
N	filed w Hygler Sther ti		17. Father's Name (First, Middle, Las	4		rran	chise Sp		ther's Name (F				vermment	
anc	d be f	) Be	Julius Kostecka	,				J	ulia Ha	luk				
Maryland	s 1 and 2 should be filed withir f Heelth end Mental Hyglene. Item 27 ie marked other then other treumatic event. Ita M	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Stree	t and Nui	mber or Rural R	loute Number	, City or Tow	n, State, Zi	ip Code)	
	and 2 Belth e n 27 io		Robert C. Kosteck	ka / Son		6524	Farmingd	la1e	Court,	Rockvi	11e, M	lary1a	and 20855	
Baltimore,	permit. Pages 1 and 2 Department of Heelth e Important: If Item 27 if eny injury or other tre ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		tate	cemetery, cre	osition (Name of matory or other pl Crematoriu	-	Januar 2007	y 18,	20c. Location Bethes		Town, State Iaryland	
Balti	permit. Departrimporta		21. Signature of Funeral Service Licensee  Robert A. Pumphrey Funeral Home/Bethesda-Chevy Ch 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3											
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that ca	used the deal	th. Do not en	ter the mode of dy	ring, such	as cardiac or re	espiratory arr	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			Infar							Onset and Death	
	/Medical Examiner		resulting in death)	Due to (o	r as a consec	quence of):								
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4	ped list	nlne	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 10	at a contect	para los ory.								
8760,	icate be executed physician and s the burial-transit	ai Examiner	that initiated events resulting in death) Last											
687	ficate p physics the	edical		d										
P.O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown									Date of deliment	very Day Year	
ds, P.	uires that t signed by Id be deta	d by Ph	Part II. Other significant conditions Multi Organ Fa	art 1.				the cause of death?						
Division of Vital Records,	aw is b	ompiete								24a. Was a autop: perfor 1 Yes	sy	prior to death?	topsy findings available completion of cause of	
ital	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?					26. P	lace of Death (					
<b>\</b>	hysic his ce I dire	2	1 ☐ Yes 2 🕅 No	Hospital: 1 □ In	patient 2	ER/Outpatie	III JU DON		Nursing Home				cify)	
ם	ing P		27. Manner of Death 1 X Natural 5 ☐ Pending		f Injury n, Day Year)	28b. Time of Injury	W			d. Describe h	ow injury occ	urred		
Sio	death death tor: /	cat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be 390 Place	of Injuny - At I	nome form si	reet, factory, offic	Yes 2		f Location (S	treet and Nur	mher or Ru	ral Route Number,	
ĭ≥	after a	Certification;	4 ☐ Homicide determine	d 200. Place buildin	g, etc. (Spec	ify)	reet, factory, offic	9		City or Tow	n, State)		, 4,	
_	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	Medical C		Physician: To the aminer: On the ba and mann	sis of examin									
	To the within Fo the somple	Me	29b. Signature and title of certifier				29c. Lice	nse numb	oer	-	29d. Date sig	ned (Monti	n, Day, Year)	
			↑ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	Un.			D19	9609			Januar	ry 18	, 2007	
	124		30. Name and address of person wh											
	Λ.		Raman R. Tuli,				vn Road,	Suit	e 202,	Gaithe	ersburg	g, Ma	ryland 20878	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 1 9 200	7 32. Re	egistrar's Sign	nature	of the second							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 5:00 PM ODANIEL JANUARY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ECOURS DAL HOSPITAL TIMORE NIA 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday) Birthplace (State or Foreign Country) ial Security Number **Funeral** Year) 196 220-80-859 1 ₺ M 2 ☐ F **Director** MAR Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 USA, 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: ò 3 Widowed 4 Divorced "natural" Completed item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 HIGRADE 10.5HIP BUILDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be POLLOCK ATHANIEL ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) NATHANIEL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important: If it any injury or c 🎜 Burial 2 Cremation 3 Removal from State ZION CEMETERY 01-4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License JR. FUNERAL BROWN FULTON AVE BALTO, MD, 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory armst, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNUEMONIA **Physician** RIGHT LUNG disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner ACQUIRED MMUNO-DEFICIENCY I Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed AIRTEIRIUSCLEROT as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending I 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 1 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: n 24 hours after death.

The Funeral Director: A pletely filled in by the fun completely within 2

> Registrar DHMH 17 Bev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

23300

130H SELOURS

29d. Date signed (Month, Day, Year)

JANUARY 17

1803F.

1342TU MD.

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. All No. 1111/10/07 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 3:29 P Regina Anne Lee 11, 2007 4c. County of Death January /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Edgewood er 1 Year If Under 24 Hrs. 2406 Hanson Rd. Apt. 41 Harford If Under 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 SAY 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M M F Yrs Director 69 29, 1937 Pennsylvania 163-30-2196 Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. fnside City Limits 10a. State 10b. County r then "natural", or Itams 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2406 Hanson Rd. Apt. 41 Funerai 21040 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then " Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Teacher Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fil Health and Mental H Be Edward James Brennan Anna Elizabeth Fisher 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Annie Lee/Daughter 1077 Jeanette Way, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 tment of b 1 Burial 2 Cremation 3 Removal from State ō Depertment of Important: If eny injury o 4 □Donation 5 □ Other (Specify) St. Mary's Cemetery 1-16-07 Hanover Township, PA 22. Name and Address of Facility
McComas Funeral Home, P. A.
1317 Cokesbury Road, Abingdon, Maryland 21009 eny in Calon 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** PANCREATIC CANCER ronths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical *IF FEMALE* 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy 2 110 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funarel Director: After this certifice 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 2 400 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 29a. Certifier crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 D0058475 JANUARY 12, 2007 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) PHILIP NIVATPUNIN 204 ATWOOD ROAD, BALTIMORE, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** :15 2007 acegina osann9 lan 5 /Medical 4c. County of Death ty Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Court Columbia Howard benere If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 N Yrs. -eb 11 190 Director 046-01-6863 Connecticut Usual Residence of Decedent filad within 72 hours aftar death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f ehow permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-1 show any njury or other traumatic event, the Medical Examinar must be putified at once. 1 Yes 2 No Funeral Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21042 U.S.A. 3341-D North Chatham Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Completed by White 3 \ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Masi John Patchen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9060 Bellwart Way Columbia, Maryland 21045 Mr. John Castellano Son in law Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery, Norwalk, CT 01/19/2007 Norwalk, CT 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv 20, Unnsee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) m unth Physician /Medical nsequence of) Examiner Stenosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be axecuted use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 chonths?

1 Yes 2 No
9 Unknown ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) cate hes baen signed by the a page 2 should be detached? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 □Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 270 No 1 🗌 Yes 3 DOA Medical Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death aspiter C. 4 hours after dean. Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitei within 24 hours a To the Funeral com: letely filled Hospitei Certifying Physician: To the best of my knowledge, death consider at the time, date and clane, and this to the nause(s) and manner as stated 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) t YAV. O CIACICS ON MI) Columbia, MI)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

22. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0650 AM JANUARY 16 200 John HENRY Mc Dowell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ST AGNES HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) Funeral Days Hours 1**X** M 2 ☐ F 79 10/21/1927 South Carolina Director 250-40-7065 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1√2 Yes 2 □ No Director Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 14. Race - American Indian, by Funeral 4502 Garrison Blvd 21 21 5 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter of Health and Mental Hygic item 27 is marked other t r other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( John Kennedy ပ Allie Hazelton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4502 Garrison Blvd., Baltimore, Maryland 21215 ce of Disposition (Name of Date 20c. Location - City or Town, State Minnie Brown / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State = 6 Department of Important: If any Injury or 4 Donation 5 Dother (Specify) Loudon Park Ceme. 01/27/2007 Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Lion 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death UROSEPSI Immediate Cause (Final 3 day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Be Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? INTESTINAL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2**2**No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ∑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA ů 28b. Time of 28a. Date of Injury 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Manpreet Mangat, MD

State Registrar

AVENUE, BALTIMORE MD 2122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANGAT

31. Date filed (Month, Day, Year)

900 CATON

32. Registrar's Signature

16,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Month (SPM Frances Leolo Miller

4a. Facility Name (If not institution, give street and number) Leola Miller 4c. County of Death 4b. City, Town or Location of Death Baltimore Avenue If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months 8. Date of Birth (Month, Day, Year) UU 25 9 9. Birthplace (State or Foreign 1 M 2 KF 245.32.4301 Usual Residence of Decedent Days Hours Country) Yrs. 4 8 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 No ltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 244 Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hild Care Provide Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) trances Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3260 Ripple Mood Daisy Lee Probinson Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, mD 4 □Donation 5 □ Other (Specify) 01.20.2007 Arbutus 22. Name and Address of Facility Voughn C. Green Juneau Service 8729 Liberty Road handall Stain (MD) 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Calcinoma months uha disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at

Director

Funeral

Completed by

Be

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Examiner

Completed by Physician/Medical

Medical Certification; To Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mental Hygiene. Importent: if item 27 is marked other than any injury or other transmitted.

signed by the ettending physicien and doe detached for use as the burial-transit page 2 should been : hes certificete within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

or Attending

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Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one) 5 Residence 6 □Other (Specify)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

yotin

5 Pending investigation

6 ☐ Could not be

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 28b. Time of

Other: 4 Nursing Home 3 DOA

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and tittle of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parikh, MD 821 N. Ewan

State Registrar

31. Date filed (Month, Day, Year)



dis

Registrar

JANUARY

WILLIAM MAHAFFEY

			1 - For State Registrar	State of Ma	aryland /		artment of I <i>tificate of</i>		Mental Hy	giene	7 0 1 1 4				
ı	Physici	an	Decedent's Name (First, Middle)						2. Date of De Month		3. Time of Death				
	/Media	al	Catherine Beatri  4a. Facility Name (If not institution,				4h City Town	or Location of Deat	January	y 17, 2007					
	Examir	er	Peartree Assiste					sadena			rundel County				
	Funeral Director		220-14-9004	6. Sex 7. Age	e (In yrs. last 81	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		19. 1925 Ma	Birthplace (State or Foreign Country) aryland				
	and wo		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits				
	death with the Maryland ms 23a or 28a-1 ehow rman Lemalified at	tor	Maryland Anne A	Arundel Co.	Pasa						1 □ Yes 2XDNio				
	th the	Jirec	10e. Street and Number				10f. Zip Code			10g. Citizen of What	t Country?				
	ath wi	ral	8004 Shadow Oak					21122		United S	States				
036	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "natural, or Items 23a or 28a-f show event, Ita Medical Exactinat must be rediffed at	by Funeral Directo	Marital Status     Never Married 2  Marrie     Married 2  Marrie     Married 4  Divorced	12. Was Decedent E Armed Forces? ed 1 ∐Yes 2 ☑Ñ If Yes, Give Year or Dates:			Vas Decedent of I f Yes, specify Cub I ☐ Yes 2 XNo	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White				
1215-0036	72 ho	eted	15. Decedent' (Specify only highest	s Education	16	5a. Deced	lent's Usual Occup	oation during most of wo d)	rkina	16b. Kind of Busine	ess/Industry				
	within sne. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	NOT use retire Home Mal		9	Or m. 11	Iomo				
N D	filed Hygie other		17. Father's Name (First, Middle, L	1			none Mar		me (First, Middle,	OWN H	One				
Maryland 2	uld be Aental rked c	To Be	Phillip Lizir	ıski				Loretta	a Kam	mer					
ary	s 1 and 2 should if Health and Men Item 27 is markedier traumatic		19a. Informant's Name/Relationsh							er, City or Town, Stat					
	1 and 1 Health 16m 27		Mra. Loretta 20a. Method of Disposition	Theresa L	Jack Blace	of Diana	sition (Alama -4		0-4-	aryland 2					
gaitimore,	Page lent o nt: If ry or		1 🚰 Burial 2 □ Cremation 4 □ Donation 5 □ Other <i>(Sp</i>	ecify)	Dular	ney (new	natory or other pla 7alley Me	em.Gard.1	/22/2007		m, Maryland				
g	permit. Departm Importa any inju		21. Signature of Funeral Service L	MO EN	www	Pe 23	Name and Addre Paceful <i>P</i> 325 York	Alternati Road T	yes Fune imonium,	eral&Crema Maryland	tion Ctr.,P.A. 21093				
	Physician /Medical Examiner	ner	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation 2325 York Road Timonium, Maryland 21  234. Hart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indicated a caused (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying cause (Disease or injury)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
09/90	ificate be executed g physicien and K	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequenc	e of):					,				
. DOX	death cert e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 [Million 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal dea		Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year				
cords, r	The law requires that the ste has been signed by th page 2 should be detache	þ	Part II. Other significant condition	is contributing to death but	t not resulting	in the un	derlying cause giv	en in Part I.			e to the cause of death?  Probably 4 □Unknown				
	The law recete has be	Completed													
<b>1</b>	Physicien: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Oth		th (Check only o						
10 11019	To the Hospital or Attending Physicien: The law within 24 Hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2:	ation: To	1 Yes 2 Tho  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	t 2 ☐ ER/0 / /Year) 28b	Outpatient Time of Injury	28c. Injur Wor	4 Li Nursing n		dence 6 (Domer (S	pecity) Assist.Liv				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could no 4 Homicide determin	building, etc.	(Specify)				City or Tou	m, State)	Rural Route Number,				
	the Hosp iin 24 hou the Funei ipletely fil	Medical	one)	Physician: To the best of xaminer: On the basis of and manner state	examination a	ge, death and/or invi	estigation, in my o	pinion, death occu	, and due to the orred at the time, o	cause(s) and manner date and place, and c	as stated. due to the cause(s)				
	T with	2	29b. Signature and title of centifier	T Slo	4		29c. Licens	-007 Y		29d. Date signed (Mo	onth, Day, Year)				
	1		Elliott Go	no completed cause of de	14	(Type, P	Print) Mad	Ion Pr	L Prior	Con Bu	In ( md, 206)				
	Sta Registra		31. Date filed (Month, Day, Year)	320 Registrar	rs Signature	SORA	de)				, ,				

07-00389 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Feryal Majedi State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 13, 2007 Year 2320 hrs **Medical Examiner** Ferial Majedi 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown **Baltimore County** Northwest Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 5. Social Security Number **Funeral** Months Days Hours Country) Director  $2^{X}$  F 213-35-0141 М 26 May 02,1980 Shiraz, Iran Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 'n 10h County 1 Yes 2X No 28a-f show s 23a or 28a-f show e notified at once. Maryland Baltimore County Cockeysville Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10403 Barrettsdelight 21030 Iran Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2X No Yes 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: Iranian Widowed è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 n/a Translator Translation 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Seyed Abolghasem Majedi Zohreh Hooshangi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Seyed A. Majedi (Father) 1838 Locust Ridge Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Jan.17, crematory or other place)
Dulaney Valley Mem.Gar Burial 2 Cremation 3 Removal from State Timonium, Maryland 2007 Donation 5 Other Specify: 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation
2325 York Road Timonium, Maryland 2 21. Signature of Funeral Service Licensee Air of I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a Narcotic intoxication Immediate Cause (Final disease **⊊**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial - tran Physician/Medical X UNPENDED \*\*AMENDED 3a, 27, 28a-f, 2/28/07 TI Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Dav Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown q Unknown of Vital Records, P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury accurred Certification: Division Natural Pending 1 Yes 2 X No Fnd 1/13/2007 unk. unk. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City p. of Town, State No. 8212 Liberty Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide Baltimore, MD determined (Specify) Shoppers Food Warehouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 14, 2007 30. Name an address of p who completed cause of death (Item 23a) rita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Marga 31. Date iled (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Ragistrar	State of I	Marylan		artment of			, 0	iene	n 7	01116
			Decedent's Name (First, Middle, L.)	ast)				200		. Date of Deat	h	<u> </u>	3. Time of Death
	Physici /Medio		Vivian Virginia	McConvil	1 <sub>e</sub>					Month January	Day 1 7 2	Year 007	8:32 P M
	Examir		4a. Facility Name (If not institution, gr				4b. City, Town,	or Location		Januar y	4c. County		0.52 F
			Joseph Richey 1	Hospice			Balt	timore					
	Funeral			Sex 7. 1 ☐ M 252 F	Age (In yrs.	last birthday)	If Under 1 Yea Months Day:		Min.	. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent	7 - W 2 24.	77	Yrs.			(	Oct.23,	1929	Mary	
	land bw		10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
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	h the	Director	10e. Street and Number	<u>.                                    </u>		OOGBIN	10f. Zip Code			10	Og. Citizen of	What Cour	ntry?
	th wil	alD	1803 Gillis Road				2179	97			USA		
	r dea	Funeral	11. Marital Status	12. Was Decede Armed Force			Was Decedent of f Yes, specify Cu	Hispanic Ori ban, Mexicar	igin? (Speci	fy Yes or No- can, etc.)		ce - Americ	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 21 If Yes, Give			1 □ Yes 2 <b>X</b> No	o Specify:				v: Whi	
3	filed within 72 hours after death with the Maryland Hygiene. yther than "naturel", or items 23s or 28s-f ehow ent, the Medical Exams as ritual by builded at	ed t	15. Decedent's 8	Year or Date	S:	16a Dece	dent's Usual Occi	ination			6b. Kind of B	usinoso/la	ducto
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9	at Hy 1 other	ВеС	17. Father's Name (First, Middle, Las					18. Mothe	er's Name (/	First, Middle, M	faiden Suman	ne)	
Maryland 21215-0036	Ment Ment arke	2	Henry Clarence	ľucker				Be	rtha W	Veber			
<u>a</u>	2 sh and sand is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (Stree	et and Numbe	er or Rural F	Route Number,	City or Town,	State, Zip	Code)
e O	1 and 1 and 1 and 27 1 and 27 1 and 27		Serena McConvil	le Daugl		311-	C Sunshi	ine Pla	ace; C				
چ	or of		1 ⊠Burial 2 ☐ Cremation 3 i		ite C	emetery, cren	natory or other pl				20c. Location -		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturei", or itema 23a or 28a-f ehow apprintury or other traumatic event, the Medical Examinat must be inclined at once.		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Cre		wn Mem.G			- 1			lle, MD
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	/Medical		disease or condition resulting in death)		as a consequ		anom	a				C	nenowy
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<i>y</i>	р <del>;</del> ;	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequ	uence of):							
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280	tificate ig phys es the	edical		d									
XOX	eath certifi attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor							23d. Da	te of delive	IV.
	death e atte	cla	in the past 12 months? 1 ☐ Yes 2 ☑ Ño	1□Live birth 4□Pregnant	at time of de		Ectopic pregnand Other (specify) _	cy					Day Year
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Hecords,	e law hes b	Completed								24a. Was an autopsy	24b.	Were autor	osy findings available inpletion of cause of
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VIII		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:						Check only one	7.		herrica
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	o the l	Med	29b. Signature and title of celtifier	and manner	stated.			se number			d. Date/signed		
	8 48 4		John	hour an	0		DSC	121		29	1/12/	7 (171011111, 1	oug, rear
	10		30. Name and address of person who			23a) (Tvna I	4	2 -11	-1		1//000	' /	
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	Sta	_	31. Date filed (Month, Day, Year)	32. Regi	strar's Signat	ure Anga	20	· · · · · · · · · · · · · · · · · · ·		V		* ***	<u> </u>
	Registr	ar	IAN 1 9 70	1 13.00	and a comment	Jan Space							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2007 John 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** DALTIMORE WASHINGTON CENTER JURNIE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) Social Security Number 7. Age (In yrs. last birthday, 1 Year **Funeral** Days Hours Min. 1 M 2 F Yrs 317-24-6446 Director 21 1937 Usual Residence of Deceder permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter of the property. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Ares 2 No Director Baltimor MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21299 Race - American Indian, Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status 1 Tes 2 La If Yes, Give Year or Dates: 1 Never Married 2 Married 2 DN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) →8. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Ince 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nelma (ear) WIFE Hammonds Lane 11210 21293 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State NOUD 4 ☐ Donation 5 Other (Specify) 1-22-07 B. Ho, remoder 21. Signatur Finer Service Licen 22. Name and Address of acility 18434 1939 Midvaller 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) Physician وعاصونين لي neumon /Medical Due to (or as a consequence of): sema Examiner Sequentially list conditions, Due to (or as a consequence of) ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Tyes 2 TNo 9□Unknown 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 1∐ Yes 2**V** No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 npatient ۴ funeral 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Year) 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wills 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cuiles Drine Gley Burnie MID Hospital Medical 301 ton Center 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 9

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM/18 per TNF 2863 1/24/07 US
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ieda 4:10PM 2007 0 10 /Medical 4a. Facility Name (If not institution, give street and 4c. County of Death 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 😾 F 87 Director 476-03-8351 Dec 10, 1919 Minnesota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2√ No Director Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5500 Friendship Blvd #905N Funeral 20815 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) secretary is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Minnie Baslington Be Wilhelm Degener Minnie ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any Injury or other trau once. Lucy C. Joyce/daughter 9218 Saint Andrews Place College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Euneral Struce Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Completinal Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be execute Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy coronary Division or Vital 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the f 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hours after within 24 hours aff

To the Funeral D

completely filled in certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) | 29a. Certifier Medical (Check on one) and manner states. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0065182

Registrar
DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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se of death (Item 23a) (Type, Print)

32. Registrar's Signature

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		For State Registrar	Please	State of Ma	aryland / Dep		lealth and	Mental Hyg	giene	le.
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Physic /Medi		Mary F		151)				Month January	Day Y	ear 5:50 AM M
Exami		4a. Facility Name (	If not institution, giv	e street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of	
		Gilchr:	ist Hospi	ce		Towson			Baltin	more
Funeral		5. Social Security I		Sex 7. Ag 1 ☐ M 2 🔀 F	e (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		r, Year)	Birthplace (State or Foreign Country)
Director		167-12-9 Usual Residence	1309	-X	95 Yrs.			May 22	, 1911	[reland
land ow It		10a. State	10b. County		10c. City, Town or I	Location				10d. Inside City Limits
Mary fied	to	MD				Baltimore	2			1.□Yes 2□No
h the r 28a r noti	Director	10e. Street and Nu	ımber			10f. Zip Code			10g. Citizen of Wh	at Country?
5-UU30 72 hours after death with the Maryland natural", or items 23a or 28a-f show lical Examiner must be notified at	a D	1000 E	ranklin A	Avenue #61	4		21221		ī	JSA
ems ems	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S. 13	B. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No-	14. Race -	American Indian, White, etc.
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filled Hyginather ent, t	Ö	17. Father's Name	(First, Middle, Las	t)	1 54	resperson	18. Mother's Nar	me (First, Middle,	Maiden Surname)	
id be ked c	To Be	Edward	l Gervin				Mary H	uohec		
shou and M mar	-	19a. Informant's N	lame/Relationship	(Type. Print)	19b. Ma	iling Address (Stree		D	r, City or Town, St	ate, Zip Code)
and 2 alth a alth a 27 ls		Sharon	Hayes/gra	ınddaughtei	840	1 Thornto	n Road Lu	thervill	e. MD 2	1093
of He litem		20a. Method of Dis	•		20b. Place of Dis	position (Name of rematory or other pla	i	Date	20c. Location - Ci	
Page ment ant: H			5 Other (Speci	□Removal from State ffy)						
partiffice, interpretation and a second banks after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show mortant: If them 27 is marked other than "natural", or items 23a or 28a-f show once, injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	uneral Service Lice	Pleasant	ant	22. Name and Addre State Ana Baltimore		rd 655 W	. Baltimo	ore Street
		23a. Part1. Enter shock, or he	the disease, or con art failure. List only	nplications that caused one cause on each li	d the death. Do not e	nter the mode of dy	ing, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
Physician		Immediate Cause disease or conditi	(Final		THE CANC	er VILL	NOWN M	MARY		Onset and Death
/Medical		resulting in death)		Due to (or as	a consequence of):			/		1041111
Examiner	L.	Sequentially list of	onditions,	b. ————	Street Market Street					
be sit	Examiner	Sequentially list of it any, leading to cause. Enter Und Cause (Disease o	mmediate erlying r injury	Due to (or as	a consequence of;					
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ath cert	M	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcome					23d. Date of	of delivery
death death e atte	icia	in the past 1: 1 ☐ Yes 2		4☐Pregnant a		B □Ectopic pregnand □ Other (specify) _	;y		Month	n Day Year
by the	hys	9 ☐ Unknow,		9□ Unknown						
The COLOS, F.O. DOX 00/00,  The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit.				contributing to death b	4	underlying cause gi	ven in Part I.			ute to the cause of death?
law requires that seem signed as been signed to seem signed to see	Completed by	_ DV VVM	nic con	dionysp					es 2 No 3	Probably 4 Unknown
e law has b	nple	-						24a. Was a autop	sy prio	ere autopsy findings available or to completion of cause of
Th icate i, pag	ပိ							1□ Yes		ath? ]Yes 2∐No
Physician: Tribis certificat	Be	25. Was case reference examiner?		Hospital:		Ott	h-a	ath (Check only or	· A	1. 000.0
P Pyy	<u>P</u>	1 ☐ Yes 21 27. Manner of Dea	No ath	1 ☐ Inpatie		elit 3 DOA	4 LI Nursing F		ence 6 Other ow injury occurred	
stori tending leath. tor: After the fune	tion	1 Natural	5 Pending investigation	(Month, Da	y Year) Injury	/ Wa	rk? ]Yes 2∐No	20d. Describe II	ow injury. occurred	
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affer affer d in bire	Certification:	4 🖺 Homicide	determined	building, e	tc. (Specify)			City or Tow	n, State)	,
ospita hours inera y fille		29a. Certifier	Certifying P	hysician: To the best	of my knowledge, de	ath occurred at the t	ime, date and place	e, and due to the o	cause(s) and mann	ner as stated.
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)	(2   Medical Exa	miner: On the basis of and manner st	ated.	investigation, in my	opinion, death occi	urred at the time, o	date and place, an	d due to the cause(s)
To t To t	Σ	29b. Signature are	Title of certifier			29c. Licen	_			Month, Day, Year)
			y co	mus		$D_{\mathcal{L}}$	8505		Arwary	4 2007
		30. Name and and	less of person who	completed cause of c	death (Item 23a) (Type	p. Print)	BAUTIM	u my Z	1204	
St	ate	31. Date filed (Mo	nth, Day, Year)	VVI) 4 2	rar's Signature		14.40.4		- 1	
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			Decedent's Name (First, Middle, Last)				_		2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Anne C. McQuillen						Januar	y 11',	2007	4:37 PM M
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	e filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or freme 23a or 28a-f ehow vent, the Maciteal Exeminer must be colified at	a D	4400 Anntana Avenue				_	21206		US	A.	
	dea	ner	11. Marital Status 12.	Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	edent of His ecify Cuban	panic Origin? , Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. [	Race - Amei Black, White	
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<u></u>	2 should be to and Mental I is marked of reumatic ave		George Martin Gre	enfelde:	r			Marga	ret Ann I	utz		
maryianu	shou nd M mar	-	19a. Informant's Name/Relationship (Type,			Mailing Addre	ss (Street ar		Rural Route Numb		wn, State, Z	(ip Code)
	and 2 ealth a m 27 is		Judy Knell/niece		1	3 Henry	7 Aven	ue Bal	timore, N	m = 212	236	
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baltimore,	permit. Pages. Department of h Importent: if ite any injury or of		21. Signature of Funeral Service Licensee Anthony D. P	leasant	+	State	and Address Anat	of Facility Omy Bo	ard 655 W	. Balt	imore	Street
P.O. Box 68/60,	by Again the death certificate be executed a signed by the attending physicien and be detached for use as the burial-transit	Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as  Due to (or as  If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death time of death	3 □Ectopic 5 □ Other (	pregnancy specify)		23e. Did	23d.	Date of del Month	ivery Day Year the cause of death?
g	puires n sign ald be								_ \ \	Yes 2□N	lo 3□Pr	obably 4 Unknown
Hecords,	The law requires that the ste has been signed by the page 2 should be detache	omplete							24a. Was auto peri 1  Yes	an 2 psy orroed? 2 No	4b. Were au prior to death? 1 ☐ Yes	itopsy findings available completion of cause of
Vital		a)						26. Place of 0	Death (Check only			
>	Attending Physicien: r death. sctor: After this certification of the funeral director.	0	examiner?	pital:	ent 2 ER/Ou	tpatient 3	OOA Othe		1	idence 6	Other (Spe	cify)
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DIVISION OF	r Atte	tific		28e. Place of Injusting, et		rm, street, fact	ory, office			(Street and N wn, State)	umber or Ru	ural Route Number,
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	Hosp 4 hou Fune	ical	(Check only 2 Medical Examine	r: On the basis o	f examination an	i, death <i>occurre</i> d/or investigati	ed at the tim on, in my op	e, date and pl inion, death o	ace, and due to the ccurred at the time	cause(s) and date and pla	d manner as ice, and due	s stated.  to the cause(s)
)	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature and title of certifier	and manner st	Q.	2	9c. License	number 0814	4	29d. Date s	igned (Mont	h, Day, Year)
			39 Name and address of person who com	pleted cause of	eat (Item 23a)	(Type, Print)	vDI	2. Su	17E 30	27	DUSA	nmozia
	St: Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 9 20	32. Registr	ar's Signature	Scare	Es .					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #10b, perInf, G863, 1/23/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 2007 **Physician** PATRICIA HELEN MOISAN JANUARY 11:23 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 55 Maryland Director December 6, 1951 215-56-8245 Usual Residence of Decedent 10b. County Anne Arundel 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Annapolis Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 136 East Lake Drive 21403 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Artist Fine Art of Health and Mental Hygie f Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis E. Mason Margaret Smithfield ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart E. Moisan / Brother Department of Health Important: If Item 27 any injury or other tr once. 136 East Lake Drive, Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2007 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee Mge M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Extensive Bilateral Preumonia 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FUlmonary Interstitial 20 years Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 9□Unknown Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Immuno deficiency 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 □ No 1 Yes 2 No 1XYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ours after death.

neral Director: A
filled in by the fu within 24 hours a To the Funeral Completely filled i

> State Registrar

0

Medical

31. Date filed (Month, Day, Year)

MILAD

29b. Signature and title of certifier

(Check only one)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892 POORAN 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D57**95**1

29d. Date signed (Month, Day, Year)

1-18-07

			. For		Maryland						•	giene, a a	~7	01122
			1 - State Registrar			Cer	tificate	e of L	Death			leg. No.	-	01166
	Physicia	an	1. Decedent's Name (First, Midd								2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		Kenneth Olive  4a. Facility Name (If not institution		ber)		4b. City,	Town, or	Location of	ol Death	) Carloca	4c. County of		
	Lxaiiiii		Union Memoria					ltin						
	Funeral Director		5. Social Security Number 218-42-225	6. Sex 7 11X M 2□F	. Age (In yrs. Ias 63	t birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Sept 10	, Year) 1943	Count	ace (State or Foreign try) y land
	Q.		Usual Residence of Decedent		10c. City,	Town or Lo	anting.							Od. Inside City Limits
	death with the Maryland ms 23a or 28e-f ehow	JO.	10a. State 10b. County			Baltin								1√2 Yes 2 No
	n the P	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of W	hat Count	try?
	ath wil	ralD	1738 E. 30th S				Mar Barrel		1213	-in2 (Co.	a if i Van as Na	USA	- America	no Indian
	fler de	Funeral	11, Marital Status 1 →Never Married 2 → Ma	Armed Ford	2 □ No	i		_			ecify Yes or No- Rican, etc.)		c, White, e	etc.
Maryland 21215-0036	in 72 hours after death with the Marylan "naturel", or items 23a or 28e-f ehow redical Examinar must be rictified at	by	3 ☐Widowed 4 ☐ Divorce	d If Yes, Give	es: 1965		1□ Yes 2		Specify:			Specify:		ack
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D D	be filed tral Hygie bd other	Be	17. Father's Name (First, Middle Daniel Olive								e (First, Middle, e Blackv	Maiden Sumame	∍)	
Ž	2 should and Men is marke eumatic	To	19a. Informant's Name/Relation			19b. Mailir	ng Address	(Street a				r, City or Town, S	State, Zip	Code)
_	7 12		Markita Lawre	nce/grandda				120111	Stre				1213	
Baltimore,	Pages 1 and nent of Heatt int: If Item 2 iry or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 🛣 Other (		tate cen	ce of Dispo netery, crer	osition (Nan matory or o	ne of ther plac	9)		Date	20c. Location - (	City or To	wn, State
Balti	permit. Page Depertment of Important: If eny Injury of ance.		21. Signature of Euneral Service Ronald		irector		Name and a latino					Baltimo	re S	treet
			23a. Part1. Enter the disease, shock, or lieart failure. Lis	or complications that can only one cause on ea	used the death.	Do not ent	ter the mod	e ol dyini	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a_ C	NKIN	4							1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	r as a conseque	nce of):							~ W	
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	icate be executed physiclen and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (c	r as a conseque	nce of):					-	1	-	
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× 68	ertifica ling ph e as th	Med	IF FEMALE:	OZe If wee oute	ome of pregnanc									-
O. Box	he death certificate r the ettending phy ched for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bi	th 2 ☐ Fetal d int at time ol dea	leath 3[	⊒Ectopic pr ☐ Other (sp			R	THE THE PARTY OF T	23d. Date Mor	e of delive	ry Day Year
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Vita	icien: certific ector.	Be	25. Was case referred to medic examiner?	Hospital:	٠.	,		Othi	ar		h (Check only o			
ō	g Phys er this eral di	n; To	1 Yes 2 □ No 27. Manner of Death	28a. Date o		28b. Time o	nt 3 DC	8c. Injun Worl	4 📙 N	ursing Ho		dence 6 Other	- 1	food buty
Sion	ending eath. or: Aft	atlo		tigation () /-04	1-2007		SA		Yes 2	<b>₹</b> √0	JUDJe	CT CHURCH	ed on	( load to the
Division of	or Attended efter death Director:	Certification		mined 288. Place	of Injury - At hom g, etc. <i>(Specify)</i>	ne, larm, st	reet, factor	y, office			28l. Location (S City or Tow	Street and Number vn, State	or Or Rura.	Thwase Mul
_	To the Hospitel or Attending Physicien: The Within 24 hours eiter death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		ing Physician: To the Il Examiner: On the ba and mann	sis of examination									
	within 7 to the To the comple	Me	29b. Signature and title of certif		0		290	c. Licens	e number			29d. Date signed	(Month, I	Day, Year)
)			· wil	16/ALOI	ma M	$\mathcal{D}$		1	100	541	03	) grue	4	102007
			30. Name and address of perso	n who completed cause	of death (Item)	23a) (Туре,	Print)	UI	Lin	1	lemoni	il Ha	JAL.	1 haltina
7	Sta		31. Date liled (Month, Day, Yea	r) 32. Re	gistrar's Signatu	ILO .						7 1		1
	Regist	rar	JAN 1	9 2007	PERLAP S	The Co	heid	2						

07-00103 John R. Padgett

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

omi i a agott		1- For State Certificate of Registrer		Reg	No. 2007	0112
Physician	1/	Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death
fedical Examin			o. City, Town, or Location of Death	January 4, 2	4c. County of Death	
		11200 block Old Marlboro Pike	Upper Marlboro	_	Prince George's	
Funeral Director		$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	If Under 1 Year If Under 24Hrs  Months Days Hours Min.	_	I Foreign	place (State or unk htry)
su y	ŀ	Usual Residence of Decedent  10a. State  10b. County  unk 10c. City, Town or Location	n			0d Inside City Limits
Varyland 28a-f show any d at once.	5	CT Bloomfield				1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director		10f. Zip Code 06002		. Citizen of What Countr	y?
er death wi	Funeral	1 Yes 2 No	Decedent of Hispanic Origin? (Sps. specify Cuban, Mexican, Puerto  Yes 2 X No specify:	pecify Yes or No- Rican, etc.)	14. Race - America White, etc.  Specify: bla	
hours afte	ed by	15 Decedent's Education (Specify only highest grade completed) 16a Decedent's	s Usual Occupation (Give kind of v st of working life. DO NOT use reti	vork don <b>eunk</b> 1		
336 thin 72 ne. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) unk unk				
21215-0036 and be filed within 72 Mental Hygiene, marked other than c event, the Medical	Be Co			(First, Middle, Ma		unk
Z 무용별히		19a. Informant's Name/Relationship (Type, Print )	Address (Street and Number or Fenn Street Balt:			Zip Code)
Md 2 alth md 2 aun 3 aun 3	-	20a. Method of Disposition 20b Place of Disposition	ion (Name of cemetery,		2Cc. Location - City or T	own, State
Baltimore, bermit Pages I a Department of He Important: If ite	Ì	4 Donation 5 X Other Specify in state				
Baltimo permit Page Department o Important: injury or oth			ated AffatoffyllyBoar 1timore, MD 212		. Baltimore	Street
Physician	$\dashv$	23a Part I Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac o	r respiratory arresi	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):			2	Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
ited d ansit	Examiner				_	
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				
lox 68 leath certif	sician/	past 12 months?  1 Live birth 2 Fet 4 Pregnant at time of death 5 Oth	al death 3 Ectopic pregna er (Specify)	ancy	23d. Date of delivery Month Da	y Year
, P.O. B ires that the d signed by the	by Phys	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I		acco use contribute to the	
cords, Plaw requires that been sign 2 should be contact.	Completed	W		24a. Was an	24b. Were auto	ppsy findings available mpletion of cause of
Reco	E S			perform 1 <b>Y</b> Yes 2		2 No
lital Rec sician: The is certificate irector, page	Be	examiner? Hospital: 4 Insertingt 2 ER/Outgations	26 Place of Death (Check  3 DOA Other Nursin		esidence 6 🗸 Other.	Scene
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	tion: To	27 Manner of Death 28a Date of Injury 28b Time of In		28d. Describe ho	w injury occurred cycle fixed object o	
Division To the Hospital or Attend within 24 hours after death To the Functal Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highway	t, factory, office building, etc.	or Town, Sta	reet and Number or Rura ite) d Marlboro Pike, Upp	
To the Hospita within 24 hours To the Funcral completely fille	Medical C					
T × Z	Me	29b. Signature and the of certifier	29c. License number O.C.M.E.	1	29d Date signed (Mont January 5, 2007	h, Day, Year)
		30. Name and address of person who completed ause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111 Pen	n Street, Baltimore, MD 21	201		
Sta Regist	ate		aD :			
Dhivin iz Rev izzu		SHIP I LOUI STATES TO SEE				

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jahuary **Physician** 2450 Theodore E. Pritchett 13 2017 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Moderno IONM AUSBIKG PONIDEKA Year If Under 24 Hrs. Social Security Number 6. Sex If Under 1 8. Date of Birth (Month, Day, Jan 5, 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 212-32-5433 71 1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Director Pittsville MDWicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21850 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examinations. 8858 Gumboro Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 D No If Yes, Give Year or Dates:

1 5 4 - 5 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: white Specify: 2 **'**54**-**57 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 manager maintenance 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be John R. Pritchett Alice Elmira Windsor ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Pritchett/spouse 8858 Gumboro Road Pittsville, MD 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pleasant 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 1 monthall teasans Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9□Unknown 9 Unknown signed by t ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy perform certificate Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examinef? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ☐ ☐ Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After or Attending 1 Natural (Month, Day Year) .s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Volume 24 hours arren within 24 hours arren within 24 hours arren blrect 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Catifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Unled sal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) 1/14/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sausbury mo Snyder 100 E. CARROLL ST. Chris 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

	1	For Amend #23a-	c Per	ing (	<b>486/3</b> ar	1919 <i>F</i> 0 Ce	artment of rtificate of	Health ar <i>Death</i>	nd Men		ne <sub>2</sub>	007	011	25
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niner	4	a. Facility Name (If not institution,	give street	and numbe	er)		4b. City, Town,	or Location of I	Death	3	4c. Co	ounty of Death		
		ohns Hopkins Ba					Baltim		Hro lo	( Dist.		O. Dist	l (Chat	r
		241-42-7128	6. Sex 1 <b>½</b> M 2			1ast birthday 76 Yrs.	Months Days		Min. (	Date of Birth Month, Day, Y -3-19;		Cour	ilace (State or ntry) AROLI	
	-	Isual Residence of Decedent  Oa State 10b. County			10c Ci	ty, Town or L	ocation					1	0d. Inside Cit	v Limits
5		,	1/A		100.01		ST END					}	1 <b>∑</b> Yes	
Director	-	0e. Street and Number	1 / 22				10f. Zip Code			100	g. Citize	n of What Cour	ntry?	
		5007 EAST HO	OFFMA	N ST	REET			1205				U.S.A	•	
by Funeral		1. Marital Status  1 Never Married 27 Marrie	ed 1	as Decede med Force Yes, 2 [ Yes, Give	is? ⊒ No		Was Decedent of If Yes, specify Cui	ban, Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)		. Race - Americ Black, White, pecify:		
		3 Widowed 4 Divorced		ear or Date	s: 1952	16a. Dece	edent's Usual Occu	pation		16	6b. Kind	of Business/In		
plet		(Specify only highes Elementary/Secondary (0-12)	t grade com		254)	(Giv	e kind of work done DO NOT use retir	during most o	of working					
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Be		7. Father's Name (First, Middle, I	_ast)							rst, Middle, Ma				
ဥ	2	DAN		PREV	ATT			MAE				DAVIS)	0-4-1	
		19a. Informant's Name/Relationsh					ing Address (Stree						1205	
	-01-	LARRY W. PREV	/A1'1'/	SON	20b.	Place of Disp	7 WRIGH osition (Name of	1	Date	LTIMO		tion - City or To		
	-	1   Burial 2 □ Cremation		al from Sta	ite	cemetery, cre	ematory or other pl	,						MD
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dical Examiner		Cause (Disease or injury that initiated events resulting in death) Last	с.	Due to (or	as a conse		scular	- Acı	cide	11			1 mon	th
by Physician/Medic		IF FEMALE:	23c. lf	yes, outco	me of preor	nancy					23	d. Date of deliv	arv.	
Physician/Me	yalolar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1	☐Live birth ☐Pregnan ☐Unknow	n 2 ∏ Fet tat time of	tal death 3	□Ectopic pregnan □ Other (specify)	су				Month		'ear
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Completed	Told line								-	24a. Was an autopsy perform		24b. Were auto prior to co death? 1  Yes	impletion of ca	available ause of
Be Compl		25. Was case referred to medical examiner?		,					of Death (C	heck only one	)			
<u> </u>	2	1 ☐ Yes 2 ☑ No	Hospi	1 Minp		☐ ER/Outpati	SILL SUL DON					Other (Speci	(y)	
atlon:	alloi.	27. Manner of Death 1 ⊠Natural 5 □ Pendin 2 □ Accident investi	9	Ba. Date of ( (Month,	Injury Day Year)	28b. Time Injury	W	uryat 'ork? ⊒Yes 2.⊡N		. De <i>s</i> cribe how	w injury	occurred		
Medical Certification:		3 ☐ Suicide 6 ☐ Could determ	not be ined 2	Be. Place of building	Injury - At , etc. <i>(Spec</i>	home, farm, s	treet, factory, offic	8	28f.	Location (Street) City or Town,	eet and State)	Number or Run	al Route Num	ber,
Clear		29a. Certifier 1 Certifyir (Check only one) 2 Medical	Examiner:	n: To the be On the bas	is of examir	nowledge, dea	ath occurred at the investigation, in my	time, date and opinion, death	place, and occurred a	due to the car at the time, da	use(s) a te and p	nd manner as s place, and due t	tated. o the cause(s	)
M		29b. Signature and title of certifie					29c. Lice	nse number		29	d. Date	signed (Month,	Day, Year)	
		Mille		MED	NCAL	DOCT	RE	5-00	00	Ja	mu	ury 14	, 200	7
			who completely	eted cause	of death (Ite	em 23a) (Type 4 0 EC	OR RE	tvenu	e B	altimo	ore,	maryla	not zi	224
State gistrar		31. Date filed (Month, Day, Year)	2007	SZ. Rec	gistrar's Sigi	Aure	reser of					7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND 1714#19b, perFH G863, 1/19/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician POSNER** LESTER January 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital ot Baltimore N/A Itimore Birthplace (State or Foreign Country) 8. Date of Birth 10/20/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Days 1 M 2 □ F Hours Months 212-03-7765 88 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits infiment of Health and Mental Hygiene. ortant: if item 27 ie marked other than "natural", or iteme 23a or 28e-f ahov Injury or other traumatic event, Ita Madical Examinar must be notified at 1 XYes 2 No MD N/A BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 6208 GIST AVENUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **BROKER** REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **POSNER** SUGAR SAMUEL JENNIE ည 19a. Informant's Name/Relationship (Type, Print) Aby Making Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If Item 27 ie any injury or other trau <del>6203</del> GIST AVENUE - BALTIMORE, MD 21215 RONA J. POSNER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 01/15/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute My Due to (or as a consequence of): Myocardial **Physician** /Medical Examiner 5-epsis

Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached to Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably trial 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes **Division of Vital** after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 → patient 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES JANUARY 11, 2007 swill all auch DOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOS91TAL OF WADHAWAN MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend 28b, perME, g865, 3/17/07 TT Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day 16, 200 **Physician** 12:38AM Ruth Brett Quarles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Poctor's Community Lan hagan 6 copes rince If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 92 Director 414-52-3040 1914 Nov 23, North Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Prince George's 1 ☐ Yes 2 No Mitchellville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Road #129 20721 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 6 1 ☐ Yes 2X No Specify: black Specify: ģ 3 N Widowed 4 □ Divorced "natural", Completed d other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 personnel work education 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) Arthur Henderson Brett Julia Rosetta Pierce 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tn once. 6377 Dockser Terrace Falls Chruch, VA 22041 Pam Quarles/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pleasant State Anatomy Board 655 W. Baltimore Street Tle sens Baltimore, MD 21201 23a. Part1. Enter the disease, obcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) amplication **Physician** erb /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 226 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? res 22 No en 8 27 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 es 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28b. Time of unk 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Fell 28c. Injury at Work? After Certification: Hospital or Attending 1 Natural 5 Pending Screen 9, 2006 M 1 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 No 2 Accident investigation newsing home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide filled in by 4 ☐ Homicide NWJing hone 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as shated. 29a. Certifier Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

01

31. Date filed (Month, Day, Year)

1-1

32 Registrar's Signature

Dhunini		1. Decedent's Name (First, Middle, Last,	)						2. Date of Dea Month		Year	3. Time of Death
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Funeral Director			. луч (/// y	65 Yrs.	Months	Days	Hours	Min.	8. Date of Birt Month, Day May 21	, 1941	MAr	place (State or Foreign ortry) cyland
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Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature!", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at ODGE.	tor	MD Baltimo		Middl		er						1 Yes 2 XNo
or 28s	Funeral Director	10e. Street and Number			10f. Zip					10g. Citizen		ntry?
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He i	-L	11. Marital Status  1 ☐ Never Married 2  Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No	10.5.	If Yes, spec	ent of mis	n, Mexican	, Puerto F	cify Yes or No- lican, etc.)	14. F	lace - Americ lack, White,	
0,1	à	3 ☐Widowed 4 ☐Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2X No	Specify:			Spe	cify: Whi	.te
"netu	etec	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a. Dec (Giv	edent's Usua re kind of wor DO NOT us	al Occupa nk done di	tion uring most	of workin	g	16b. Kind of	Business/In	dustry
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rked tic ev	To B	Leonard G. Joh	nson				$\mathbf{L}_{0}$	ouis	e P.	Krebs		
Teum.		19a. Informant's Name/Relationship (T) Julian Ross / h							Route Number Balti			
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importe eny inju pnce.		21. Signature of Funeral Service Licens		10000	22. Name an	d Address	s of Facility	300	MAce	Ave.	Balto	. MD
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To the Funeral Director: Aler this certificate has completely filled in by the funeral director, page 2.	cai (	(Check only 2 Medical Exam)	sician: To the best of my	knowledge, dea	ath occurred	at the time	e, date and	d place, a	nd due to the o	cause(s) and	manner as s	tated.
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<b>₽</b> 00		29b. Signature and title of certifier				: License		41		29d. Date sig		
			ompleted cause of death (i	Item 23a) /Tu	a Print		0-	, T			0-0	7 D 21230
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		30. Name and address of person who o	OM VO	1920	Cum	phe	UB	124	Sat	Dunas	~ M	D 2636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month N. **Physician** FIE 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE

If Under 1 Year If Under 24 Hrs. 8. Date of 5WICK 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 220-30-6450 Min. Months 1 M 2 F 86 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 17 is marked other than "natural", or items 23a or 28a-f sho traumatic avent, the Medical Examinar must be notified at 1 Yes 2 No Director MARVIAND 10e. Street and Number 10g. Citizen of What Country? itsms 23a Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2ENo þ 3 ₩idowed 4 Divorced BLACK "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) H GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental I WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i BROWN (DAUGHTER) BALTO. LULASTINE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. BUTUS CEMETERY 01-22 4 □Donatiog S □ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility JR, FUNERAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteroscienta Cardiovascular disease Physician disease or condition resulting in death) 12a3 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached o 9 Unknown 9 Unknow ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 1 ☐ Yes or Attending Physician: Diractor: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Division 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) JAN 19 2007

29b. Signature and title of certifier



Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Howard January 12:00 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Chicago Ave. nit Worcester 5. Social Security Number Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1.1 M 2□F Months Days Hours Min. 64 Yrs. Director Unknown January 28 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" --- any injury or other traumatic events. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No Ocean C: laryland 10e. Street and Number 10g. Citizen of What Country? 1406 Chicago 21843 USA 12. Was Decedent Ever in U.S. Armed Forces? 1⊠ Yes 2 □ No If Yes, Give Year or Dates: Uniknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ျှ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Richie Ucean City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry January 18,2007 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DVANCED VAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physiclan: The law requires that the death certificate be execute the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown 3 DEctopic pregnancy in the past 12 months? Month Day Year been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2□ No 3 Probably 4 ☐Unknown 24a. Was an autopsy performa cate has b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Medical Certification: To Be 26. Place of Death (Check only one) 2 100 Hospital: 1 TYes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 □Other (Specify) After this 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 2 Accident 5 Pending investigation Notice now after death.

To the Funeral Director: Aft 1 ☐ Yes 2 🗌 No 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ie of certifier 29b. Signature a 29d. Date signed (Month, Day, Year) MO

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person wi

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

MP

32. Registrar's Signature

M. Ilcr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Mitchell Allen Rose 1- For State Certificate of Death Registra Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Mitchell Allen 1554 hrs Rose Medical Examiner January 14, 2007 4b. City, Town, or Location of Death c. County of Death 4a Facility Name (if not institution, give street and number) Frederick Washington Smithsburg 4400 Foxville Rd If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or 7. Age (In yrs. last birthdav) 5. Social Security Number 6 Sex **Funeral** 296-66-9259 Months Davs Hours 8/17/1968 IN 38 Director Country) 1 XM 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County Alle 10a State Smithsburg MD Washington Yes 2 X No 28a-f show s 23a or 28a-f show notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21783 USA 14330 Pleaseant Valley Road uneral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11, Marital Status or items? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married Married White 2 X No Yes "natural", or 4 Divorced If Yes, Give Year Specify 1 Yes 2 X No specify 3 Widowed ⋧ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72. nent of Health and Mental Hygiene aut: If item 27 is marked other than " marked other than " MD 21215-0036 Project Manager Mechanical Contractor 3 12 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Virginia R. Linginfelter Arzia Mitchell Rose 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Kathy Smallwood / Sister 425 South Spring Street, New Paris, OH 45347 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, t: If it crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 1/19/2007 New Paris, OH Spring Lawn Cemetery ment c Donation 5 Other Specify 21. Signature of Funeral Service Licensee 2. Name and Address of Eachlity Charles L. Stevens Funeral Home Inc. Moushall 21230 1501 East Fort Avenue, Baltimore, MD louto. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Coronary Artery Thrombus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Atherosclerotic Cardiovascular Disease Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical \* AME#46 Per ME G863 1/19/07 Jh UNPENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery phy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25 Was case referred to medica To the Hospital or Attending Physician: Division of Vital director Be Hospital 1 Inpatient Other<sub>4</sub> Nursing Home 5 Residence 6 V Other: Scene DOA ER/Outpatient 3 After this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 5 Pending 1 Yes 2 No death. To the Funeral Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E January 15, 2007 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

07-00406

			For State Registrar		State	of Maryl			nent of H	ealth and i Death	Mental Hy	giene Reg. No.	007	01132
			Decedent's Name (First, Mid.	de, Last)							2. Date of De	ath		3. Time of Death
	Physicia		Virginia	,	205.	3					Jan	Day	200 >	6:09 AM
	/Medic Examin		4a. Facility Name (If not instituti	on, give s				4b.	City, Town, or	Location of Deat	h		ounty of Death	
			Howard Canty	Gen	ens	14030			Col	2000	4		towa	
	Funeral		5. Social Security Number	6. Sex	( ]M 2∏∑F	7. Age (In	yrs. last birt		Inder 1 Year Inths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di June 2	th ay, Year) 102	9. Birth Cou	place (State or Foreign intry)
	Director		219-74-8391 Usuel Residence of Decedent			0	9				June 2	, 193	West	Virginia
	ytand ytand		10a. State 10b. Coun	y	<del></del>	100	. City, Town	or Locatio	n					10d. Inside City Limits
:	e Mar	ctor	MD Bal	timo	re		Owing	gs Mi	11s					1 ☐ Yes 2 🗖 No
3	n with the	al Director	10e. Street and Number Rosewood State	Hos	pital			10	of. Zip Code	21117		10g. Citize	USA	untry?
215-0036	be lied within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "naturel", or iteme 23a or 28s-f show event, it a Modical Examinar must be notified at	by Funeral	11. Marital Status  1 📉 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗆 Divorce	arnied	Armed F	2∭No live	in U.S.	If Yes	Decedent of Hi s, specify Cuba res 2∏ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		. Race - Amer Black, White pecify: W	
ב ה	72 ho natur	ted	15. Decede (Specify only high	ent's Edur	cation	")	16a.	(Give kind	S Usual Occupa	turing most of wo	rking	16b. Kind	of Business/li	ndustry
7	within some than "	Completed	Elementary/Secondary (0-12			(1-4or 5+)		life. DO N	IOT use retired	)	•			
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⊆ .		o Be	Charles Ross	,, 220.,							Bishop	,	ŕ	
_	d 2 should th and Men ?7 is marke treumatic	၉	19a. Informant's Name/Relatio	nship (Ty	pe, Print)		19b.	Mailing Ad	Idress (Street a	and Number or Ri	<del>-</del>	er, City or 1	Town, State, Zi	ip Code)
Ž	7 18		Merry Jane Fu	ller,	/siste	r	28	37 Jei	f Lewi	s Road D	ou las.	GA 31	.533	
o e	2 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other		lemoval fron		Ob. Place of	Disposition			Date		ation - City or T	fown, State
Balt	permit. Page Department of Important: if eny injury or		21. Signature of Funeral Service Anthon	e License y D	Pleas	ant	u.t			tomy Boa MD 21		V. Bal	timore	Street
			23a. Part1. Enter the disease, shock, or heart failure. L	or compli	ications that	caused the	death. Do r	not enter th	e mode of dying	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	or only of		0500	Om ice	. /	Pro					Onset and Death
	/Medical		resulting in death)			o (or as a co			7 7,00	~				3
	Examiner		Sequentially list conditions,	, l	D			40(T2)						
	be dist	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	200 (0	o (or as a co	กของนอกจะจ	Oty						
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	ď	C. Due to	o (or as a co	nsequence	of):					_	
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68	ufficate g physi as the l	ledic												
O. Box	The law requires that the death certific ite has been signed by the attending p page 2 should be deteched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2	1 Live	utcome of problems	Fetal death		opic pregnancy ner (specify)			23	d. Date of deli Month	very Day Year
o <u>.</u>	s that		Part II. Other significant cond	i <b>tions</b> col	ntributing to	death but no	ot resulting in	the under	lying cause give	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
<u>5</u>	w requires been sign should be	pa pa	Fecal Impa	chios	2, 1	Sypt	2050	Sio.	515		1 🗆	Yes 2 🗗	No 3□Pro	bably 4 Unknown
ပ္တ	aw re	Completed by				0'					24a. Wa		24b. Were aut	topsy findings available completion of cause of
ř		E O									perf 1 ☐ Yes	ormed!	death?	2 □ No
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	To the Ho within 24 I To the Fu completely	Med	one)  29b. Signature and title of cert	Mer	and ma	inner stated.			29c. License	e number	7	29d. Date	signed (Month	n, Day, Year)
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			30. Name and address of pers	on who co	ompleted ca	use of death	(Item 23a)	(Type, Prin	10 1					, 200 S 6 OO 21044
			r veles	7	10	7/24	Signature	He	Pato	xent	PKW	4 0	dembo	0 00 21044
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ORIGINAL

07-00435 Kurt David Rollins

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

urt David Rollir		SIA 1- For State Registrar	te of Maryland		ent of Health <i>ate of Death</i>	and Mental		Reg. No. 200	7 0113
Physicia Medical Exami	an/	1 Decedent's Name (First, Middle,	// / / /			-	Date of Dea     Month	ath Day Year	3 Time of Death 0858 hrs
		4a. Facility Name (if not institution,		· · · · ·		n, or Location of De	January 1	4c. County of De	
Funeral		Harbor Hospital Center  5. Social Security Number  6. Social Security Number	S. Sex 7. Age	e (In yrs last bir	Baltimo		Hrs. 8. Date of B	irth(MM/DD/YYYY) 9.	Birtholace (State or
Director		200100101	1 M 2 F	46	Yrs. Months		Vin. 3-16	Con	eign Country)
/ any		Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town	or Location				10d. Inside City Limits
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er death	Funeral	Never Married 2 Mar  Widowed 4 Divor		No	1 Yes 2	Cuban, Mexican, Pue	rto Rican, etc.)	White, etc	LiTE
2 hours aft "natural" L Examine	d by	15. Decedent's Education (Specif	or Dates:		Decedent's Usual Oc	cupation (Give kind		Specify (16b. Kind of Busines	ss/Industry
5-0036 ed within 72 hours tygiene other than "natur	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during most of working	•	retirea)		مسدد.
5-00 led with Hygiene other the Me	Com	17. Father's Name (First, Middle, L	ast)		BINET MA	18.Mother's Na		Maiden Surname)	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	o Be	KENNETH R. Roll 19a. Informant's Name/Relationshi	lins SR.	140	h Afrikan Addana	MARTH	A E. M	THER imb r, City or Town, St	
MD 2 Id 2 shoul lith and N m 27 is n aumatie		KENNETH R. Rollins		10		Street and Number of			ate, Zip Code)
ore, tre		20a. Method of Disposition  1 Burial 2 Cremation	7	- 1	of Disposition (Name lory or other place)		Date	20c. Location - City	or Town, State
Baltimore, permit Pages l at Department of He. Important: If ite		4 Donation 5 Other Spe	cify:	1.4	CIFTS REQUIT		-18-07	HANDVER,	MD.
Bal permi Depar Impo injur		21. Site turn of Turneral Service Li	censer	- '				mation Center, P.A.	
Physician /Medical	1	23a. Part I. Enter the disease, or or failure. List only one cause of	omplications that caused	the death. Do n	ot enter the mode of c	lying, such as cardia	c or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examiner	ì	Immediate Cause (Final disease or condition resulting in death)	a Atheroscler  Due to (or as a conse	otic card	iovasculkar	disease com	licated b	y alcohol	Death
	_	Sequentially list conditions,	b		*	1001011			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse						
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Box 68760, e death certificate be executed the attending physician and ed for use as the bunal - transit	Medical	X UNPENDED	AMENDED	.27.28a-f	, perME, C86	3m 1/23/200	7 TT	<u>-</u>	
8760, ifficate be ag physicil		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnancy		3 Ectopic pred		23d. Date of deliv	ery Day Year
Box 687  e death certific  the attending p  ed for use as th	sician/	past 12 months?  1 Yes 2 No 9 Unkn	4 Pregnant at		Ental death  Other (Specify		grandy	Worth	Day Teal
~ ÷ ≥ 5 €	Phy	Part II. Other significant conditio	a ouknown	but not resultin	g in the underlying ca	use given in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
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cords law requi has been 2 should	Completed	·				<del></del>	24a Was		autopsy findings available occompletion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical	- I		26	Place of Death (Che	1 🗸 Yes		
Division of Vital Records, rate or Attending Physician: The law requir rs after death al Director: After this certificate has been sted in by the funeral director, page 2 should the	o Be	examiner?	Hospital. 1 Inpatie	nt 2 🗸 ER/O		Other -	rsing Home 5	Residence 6 Ot	ner
n of ding Ph	D: T	27. Manner of Death  1 Natural 5 Pendir	28a. Date of Inju (Month, Day,Yo	y 28b. ear)	Time of Injury 280	Injury at Work? Yes 2 X No	28d Describe	how injury occurred	
Divísion piral or Attenc ours after death reral Director:	Certification	2 Accident Investi	gation ind 1/16/0	7 Fn ury - At home, fa	d 8:00 am		unknown 28f. Location (	(Street and Number or	Rural Route Number, City
Div spital o	Certi	4 Homicide determ	danad I a la la	Found: pr	ivate dwelli	ng	Baltimore	State) 3918 Brooms, MD	Rural Route Number, City  oklyn Ave.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	29a Certifier (Check only one) 1 Certifying Phy	sician: To the best of my iner: On the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of the basis of example of the basis of the basis of example of the basis of	knowledge, de nination and/or i	ath occurred at the tin nvestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau d at the time, date	se(s) and manner as signal and place, and due to	ated the cause(s)
To with	Mec	29b Signature and little of certifier	and magner stated			icense number		29d. Date signed (#	
0/5		XIII	VIV.			D.C.M.E.		January 17, 20	07
HAR		30. Name and sold ress of person was Susan Hogan MD. A	tho completed cause of desistant Medical Ex		11 Penn Street.	Baltimore, MD	21201		
	ate	31. Date filed (Mon W Day, Year)	2007 32 Registrar		poles				
Regist	rar	-4-1 5 4 445 5	A - Marie Marie	3	1				

			For State Registrar	State of Maryland		artment of He		ental Hygiene Reg. No	2007	01134
	3/2		Decedent's Name (First, Middle, Last)				2	. Date of Death		3. Time of Death
	Physicia		Barbara P.	Schaafsi	na			Month Day	200.7	6:00 AM
	/Medic		4a. Facility Name (If not institution, give s		7,04	4b. City, Town, or Lo			County of Death	
	Examin	er	2905 Overlar	1 A		Ba.1+	imore		NIA	
			Social Security Number     6. Sex		ast birthday)	If Under 1 Year   I	f Under 24 Hrs. 8	Date of Birth	9. Birth	place (State or Foreign
н	Funeral Director			M 200 90	Yrs.	Months Days	Hours Min.	(Month, Day, Year)	13 N.E	ntry)
	Director	1	Usual Residence of Decedent	1 40	,					0 70
	land ow		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
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	within 72 hours after death with the Maryland ene. then "naturaf", or itema 23a or 28a-f ehow the Madical Examinar must be motified at	Funeral Director		12. Was Decedent Ever in U.	S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Speci	ify Yes or No-	14. Race - Ameri	
	ter d	ä	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	i		Mexican, Puerto Ri	can, etc.)	Black, White,	
21215-0036	rs af	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2,23 No	Specify:		Specify: W	hite
Ş	"natural",	B	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occupation	on	16b. K	ind of Business/Ir	ndustry
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12	with the se	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Homem	aker		Own	Home
9	be filed within tal Hygiene. d other then event, the Ma		17. Father's Name (First, Middle, Last)			1.	8. Mother's Name (	First, Middle, Maiden	Sumame)	
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2	should be filed with and Mental Hygiene is marked other the aumatic event, the	ဥ	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address (Street and	d Number or Rural	Route Number, City of	or Town, State, Zi	p Code)
Maryland	s 1 and 2 should Health and Meritem 27 is merke		Kathrun E. Schaafsma	1	7915	Overland	Ave Pn	Himace .	MN 71	214
	ten 2 theal tem 2 other		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of	Da		ocation - City or T	own, State
ğ	80-		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		matory or other place)	January January	11.2007 Ha	mover,	am
ij	t. Pag tment tant: I		4 ⊠Donation 5 □ Other (Specify)			31 HIS Regis		-		
Baltimore,	permit. Pagi Department Important: I eny injury o		21. Signature of Funeral Service License	96		2. Name and Address	Ana	010.09	ts Regis	MB 21076
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			23a: Part. Enter the disease, or compli shock, or heart failure. List only or	ne cause on each line.	n. To not en	ter the mode of dying,	Such as cardiac or	respiratory arrest,		Interval Between Onset and Death
1	Pnysician		Immediate Cause (Final disease or condition	Dehydr	atio-	1		1		
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
	Lammer	L	Sequentially list conditions,	).						
	ם יי	<u> </u>	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cualto (or as a nonseq	mende or):					
Y	The law requires that the death certificate be executed at hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq						
ò	e exc ien a urial-	Ê	1050king in doubly East	Due to (or as a conseq	derice di):					
3760,	ate b hysic the b	Ical		1						
89	death certifical ettending phy ifor use as th	Me	IF FEMALE:						-	
Вох	th ce tendi	ar/	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		☐Ectopic pregnancy			23d. Date of delive Month	rery Day Year
	dea ne et ed fo	SCI	in the past 12 months? 1 Pyes 2 Pyo	4 Pregnant at time of d 9 Unknown	eath 5	Other (specify)			Wichigh	Suy Tour
P.0	ires that the death cer signed by the ettendir d be detached for use	Physician/Med	9 Unknown					1		
	as the	Š	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	inderlying cause given	in Part I.			the cause of death?
Ď	an sin	P	Depression					1 ☐ Yes 2	Man 3 □ Pro	bably 4 Unknown
Records,	s be	pet	Pulmonary	Embolus				24a. Was an autopsy	24b. Were aut	opsy findings available
Be	he le e he age	Completed						performed?	death?	ompletion of cause of
Vital	ifficel	O	25. Was case referred to medical				26. Place of Death		1 1 100	2,000
5	Physiclan: rthis certificant director,	100	evaminer?	lospital:	ER/Outpatie	Othon		~	6 □Other (Spec	ufv)
of	Phy ratio	2	27. Manner of Death	28a. Date of Injury	28b. Time o	-		8d. Describe how inju		,
S C	ding P. Afte fune	5	1 Natural 5 ☐ Pending	(Morith, Day Year)	Injury		es 2 🗆 No			
Si	Attending r death.	Ca	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, si	treet, factory, office	28	8f. Location (Street a	nd Number or Rui	ral Route Number,
Division	or after Dire	Certification;	4 Homicide determined	building, etc. (Special	(y)			City or Town, Stat	θ)	
_	To the Hoepital or Attending Physician: The law require within 24 hours after death. To the Funaral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	2	29a. Certifier Certifying Phy	sician: To the best of my kno	wiedge, dea	th occurred at the time	, date and place, ar	nd due to the cause(s	and manner as	stated.
	24 h Fur etely	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ition and/or ii	nvestigation, in my opin	nion, death occurre	d at the time, date an	d place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29d. Da	ate signed (Month	, Day, Year)
	ŭ⊣≮⊣		1 to	I. FUT M	0	03	3220		Hulo	7
	3		20 Name and address of the	ompleted cause of death (Iter	n 23a) (Type		, , , ,		11110	1
	1		30. Name and address of person who co	3730 Falls	R	Balto. N	10 212	11		
	\ 		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	15 -5.10. 10	- 10 - 2- 1			
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ORIGINAL

			1 - For State Registrar	State of Mai	-	artmen ertificate			and M	ental Hy	giene Reg. Ne	2007	0113	5
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Marjorie Adele Stei	nmetz						2. Date of De Month	Da	7 200	3. Time of Dea	
	Examir	ner	4a. Facility Name (If not institution, give s			1		Location of	of Death		1	County of Dea		
	- 180		Manorcare Healthser			Rux		If Under:	24 Hrs	0 Data of D		Baltimo		
	Funeral Director		217-10-3493	M 2XF	(In yrs. last birthday 84 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April 1	2,19	922 Mar	thplace (State or Fo. buntry) 'yland	eign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	_ocation	_					······································	10d. Inside City Li	mits
	a-f eh	ctor	Maryland Baltimore	j	Ruxton								1 ☐ Yes 2 🕅	Į No
	vith th	Dire	10e. Street and Number			10f. Zip	Code 204				_	itizen of What Co	-	
	eath v	eral	7001 N. Charles St.	2. Was Decedent Ev	ver in U.S. 13			isnanic Orio	ain? (Spe	city Yes or No		ted Sta		
336	be filed within 72 hours after death with the Maryland tal Hygiane. Id other than "natural, or iteme 23a or 28a-f ehow event, if a Medical Exercities must be notified at	by Funeral Director	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	3.3.	If Yes, spec		Specify:		cify Yes or No Rican, etc.)		Black, Whi		
2-0	72 hou natura	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dec	edent's Usua e kind of wor	al Occupa	ation during mosi	t of workir	ng	16b. h	Kind of Business	/Industry	
121	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		o kind of wor DO NOT us nomema		1)		3		wn home		
d 2	e filed v I Hygia other t		12 17. Father's Name (First, Middle, Last)		I	iomenia	Ker	18. Mothe	er's Name	(First, Middle	1			
ylan	Mental Mental arked o	To Be	August Steinmetz					Esth	er P	isto1				
Mar	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type) Perry Eisman/Brothe			ling Address  Lake				Route Numb 1timor		or Town, State, D 2121		
ē,	of Health of Health item 27 i		20a. Method of Disposition		20b. Place of Disp					ate		ocation - City or		
OM.	Pages ment of the ant: If its ury or of		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Loudon Pa				an. 1	9,2007	Ва	1timore	, Marylan	d
Baltimore, Maryland 21215-0036	permit. Page Department Important: If any injury or		21. Signature of Funeral Service License	ell		22. Name an <b>Mi</b> 65	d Addres tche 00 Y	ss of Facility 11-Wi ork R	edef	eld Fu Balti	nera more	1 Home 2, MD 2	Inc. 1212	
	Physician /Medical		23a, art1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	e cause on each line	5	trok	e of dyin	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Betweer Onset and Deatl	
×	Examiner	er	Sequentiafly list conditions, if any, leading to immediate		consequence of):									
8760,	cate be executed physician and the burial-transit	Ical Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Email Uniderlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of);									
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pr □ Other (sp						23d. Date of de Month	livery Day Year	
	luires that n signed b	by	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying c	ause give	en in Part I.				1	o the cause of death robably 4 DUnkn	
Vital Records,		Completed								24a. Was auto perfe 1 Yes	psy ormed?	prior to death?	utopsy findings avail completion of cause	able of
/ita	ysician: is certific director,	Be (	25. Was case referred to medical examiner?				T Ou		of Death	Check only	one			
of	Physi this c	2	1 ☐ Yes 2 ☑ No	ospital: 1  Inpatient				ge Nu		ne 5 Res		6 Other (Spe	cify)	
O	Attending Physician: r death. ector: After this certific by the funeral director,	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day	Year) Injury	м	8c. Injun Worl	k?` Yes 2 □ l		.ou. Describe	now inje	ary occurred		
Division	i or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	street, factory	, office		2	28f. Location ( City or To			ural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of ner: On the basis of e and manner state	examination and/or	ath occurred investigation	at the tin	ne, date an pinion, dea	nd place, a th occurre	and due to the ed at the time,	cause(s	s) and manner a nd place, and du	s stated. a to the cause(s)	
	To the I	Ž	29b. Signature and title of certifier	11 ~		290	. Licens	e number			29d. Da	ate signed (Mon	h, Day, Year)	
)	n		Juny J. St	sperm )		I	)25	7662			1/	18/200	7	
	.7		30. Name and address of person who co	_	ath (Item 23a) (Typi 333 W C	e, Print) Wer	-T'S	T Rm	540	30	4761	18/200 M) 21.	218	
100 H	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	all!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Year Physician CSSO AM mwar 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5739 Goldfinch Court Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/01/1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2X F 327-18-2810 Yrs 91 ILDirector Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28e-f show the Medical Examinar must be notified at MD Howard Ellicott City 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5739 Goldfinch Court 21043 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Nursing Assistant Hospital other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othing or other traumatic event ADES. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Stratton Sadie L. Guy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5739 Goldfinch Court, Ellicott City, MD 21043 Sadie Rerkins / Daughter Date UNLY. 20c. Location - City or Town, State UNLY. 20b. Place of Disposition (Name of JALA), cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21. Signature of Funeral Service Licensee 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Tribreshing **Physician** Jements A yrs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖼 No 9 Unknown 9 Unknown signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No 1 Tyes 2 🗌 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2192No 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after To the Funerel Dire pelli

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address

[[05] 32. Registrar's Signature

L HIL

person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 VINCENT JANUARY 18 /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BAYVIEW MEDICAL CENTER HOPKINS If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) June 7,1926 5. Social Security Number Under 1 Year **Funeral** Days 1 M 2 □ F MAryland 80 Director 217-20-6157 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural" or items on other trainments. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No **Funeral Director** Maryland Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 USA 7254 Stratton Way 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2√2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) American Can Company 12 years Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose DiMarino Samuel Sortino ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21224 7254 Stratton Way, Dundalk, Maryland wife Marie Sortino 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January Oak Lawn Cemetery 22,2007 Dundalk, Maryland 4 Donation 5 Dother (Specify) 21. Si matu a of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 r complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final week STRUKE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certificate 1∐ Yes 2 Z No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ Mo P this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Certification: (Month, Day Year) or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division To the Hospital State

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Records,

or Vital

DR. KATHERINE THOMAS 31. Date filed (Month, Day, Year) JAN 1-9 200

29b. Signature and title of certifier

4940 Eas Eastern

ne and address of berson who completed cause of death (Item 23a) (Type, Print)

Baltimore, MD

29d. Date signed (Month, Day, Year)

2007

Registrar

29c. License number

venue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9863 1-26-07 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Cleo Louise Smith 13, 2007 January 6:58 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Springs Montgomery 5. Social Security 8578 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 1 XF Yrs. 579-05-<del>1917</del> 89 25, 1917 <u>Pennsylvania</u> Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 1 XYes 2 No notified Director DC District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō must be USA 20011 6205 14th St. NW 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. or items 11. Marital Status Black White etc. event, the Medical Examiner 1 Never Married 2 Married 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. Be Completed by 3X Widowed 4 ☐ Divorced Black natural 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) US Treasury Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Department of Health and Ment Important: If item 27 is marked any injury or other traumatic e 2 Carrie Louise Hockaday Grover Cleveland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Mathews / Dauhgter 6205 14th St. NW, Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Baptist Cem. 1-18-07 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. Cussell 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29b. Signature and titlerof certifier 29c. License number 29d. Date signed (Month. Dav. Year) D32332 1 - 13 - 0730. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave., #220, Silver Spring, MD 20910 S.K. Gupta, MD 31. Date filed (Month 32 Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Physician/ Month Day January 7, 2007 1650 hrs **Medical Examiner** James Sexton 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Bon Secours Hospital Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Numberunk 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Director 38 CountryMaryland 1 X M 2 F Dec 27, 1968 Usual Residence of Decedent 'n 10a State 10c. City, Town or Location 10d Inside City Limits 10b. County Yes 2 28a-f show MD Baltimore with the Maryland Directo s 23a or 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 1830 W. Lombard Street 21223 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian, Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 XNever Married 2 Married Yes If Yes, Give Year Widowed Divorced Yes 2X No specify Specify: white ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done  ${
m unk}$  16b. Kind of Business/Industry unk Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 be filed within unk unk Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) t: If item 27 is marked other tranmatic event, t James Dean Sexton Lillian Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Esther Benjamin/aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town. State crematory or other place) 1 Burial 2 Cremation 3 Removal from State tant: Donation 5 X Other Specify in state Signature of Funeral Service Anthony <sup>22</sup> Name and Address of Facil State Anatomy Neasant <sup>™</sup>Board 655 W. Baltimore Street 21201 Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure List only one cause on each line Between Onset and /Medical Death a Alcohol and heroin intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED attending physician or use as the burial #23a,27,28a-f, perME, g863, 1/23/07 TT The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other<sub>4</sub> this Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 2 After 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Natura Pending Yes 2 X No within 24 hours after death To the Funeral Director: /7/2007 Fnd 4:17 pm unknown Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1830 W. Lombard St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined (Specify) residence Baltimore Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certified 29c. License number 29d Date signed (Month, Day. Year) O.C.M.E. January 8, 2007 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 10, 2007 **Physician** 5:45 MA Joan Shipp /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 01ney Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | Mar 25, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Numberunk 6. Sex **Funeral** 1 ☐ M 2 🛱 F 73 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Extendion must be rediffied at once. 1 Yes 2 No Director Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 2601 Bel Pre Road Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14 Bace - American Indian unk 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18111 Prince Philip Drive Olney, MD 20832 Montgomery General Hospital 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in state 21. Signature of Funeral Service Licensee Anthony D. Fleasant Thate and Address of Facility Board 655 W. Baltimore Street reasan methony Baltimore, MD 21201 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Recurrent plemal Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Emphase m Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): neart Failure Examiner attending physicien and for use as the burial-transit Congestul The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **S**.No 26. Place of Death Check only one 25. Was case referred to medical Be examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending el or Attendin s after death. 1 Tes 2 No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel of within 24 hours af To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier F010111 mukemil Abdella my 18 PPZ 00Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registr<u>ar</u> Mukemil

31. Date filed (Month, Day, Year)

Fere jo

JAN 1 9 2007

<u>Abdella</u>

32. Registrar's Signature

Cheverly Md.

20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Usate of Maryland / Department of Health Andrew / Department of Health / Department of Health / Department of Health / Department / Depa 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** January 7, 2007 1:51 PM M Jeffrey Singman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1018 Bell Avenue Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) Il Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Davs Hours 56 Washington DC Director 213-50-3232 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rthan "naturel", or Items 23a or 28a-f shov the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 1018 Bell Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: white à 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ lawyer lega1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Heelth and Mental I David Singman of Heelth and Ment Item 27 Is marked r other traumatics Sylvia Silverman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2421 Ogden Square Gambrills, MD Kyoung Kim/spouse 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 = 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 1/26/2007 Odenton, MD Columnia Mortuary Syrs. Inc. P.O. Box 58007 4 □ Donation 5 MOther (Specify) in state West Arundel Crematory 21. Signature of Funeral Service Licensee Pleasant 62 Name and Address of Facility Board inthony 1 to -21201 Washington, D.C. 20037 MD 23a. Part1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Interiosclero+ resulting in death) /Medical Due to (or as a consequence of) Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy ō Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an hes r this certificete hes performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one examiner? 12 Yes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000054 address of person who completed cause of death (Item 23a) (Type, Print) ONES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **JAN 1 9** 2007

			For State Registrar	State of	Maryland		artmen <i>tificat</i>			d Me		giene Reg. No.	2 U	07	01142
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1	)		30. Name and address of person who	completed caus	e of death (Item	n 23a) (Type,	Print)	3.0	4)	MI	0712	2.1	12	Laur	7 -c. L. Steele, MD.
-			31. Date filed (Month, Day, Year)		€gistrar's Signa		Ver.	Jac	npore	- 6	12	01	24.5		MD.
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		Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death					
Physi		Robert Herbert Stange		January 18	8, 2007	9:30 A M					
	dical niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death						
		8941 Chapel Avenue	Ellicott City		oward						
Funera Directo	_	5. Social Security Number 218-28-6809 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 21,	9. Birthplac Country 1929 Maryla	ce (State or Foreign and					
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Mary id 2 sho tth and 1 27 is ma		, , , , , , , , , , , , , , , , , , , ,	ng Address (Street and Number or Rus								
and and mark		Johanna M. Stange/sister_in_law 8941	Chapel Avenue El	licott Cit	y MD 2104: Location - City or Town	3 n State					
Pages 1 nent of H nut: If ite		1 Burial 2 Acremation 3 Hemoval from State	osition (Name of matory or other place)		ltsville, N						
<b>Galtimore,</b> Dermit. Pages 1 ar Department of Hea mportant: If item any injury or othe			ke Crematory 01/1								
<b>Baltimore</b> , permit. Pages 1 an Department of Heal Important: If item 2 any injury or other	ouce		2. Name and Address of Facility Oing Home Cremati								
		23a Part 1. Enter the disease, or complications that caused the death. Do not en	everly L. Heckrot ter the mode of dying, such as cardiac	or respiratory arrest,	А	Approximate					
		shock, or heart failure. List only one cause on each line.				nterval Between Onset and Death Years					
Pnysicia /Medic	_	Immediate Cause (Final disease or condition resulting in death)  Congestive Heart  a	raliule			years					
Examin	er										
	- i		ue to (or as a consequence of):								
ocuted Ind	Fyamina	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):									
ox 68760, contilicate be executed right physician and use as the burial-transit											
cate physi the t	100	d									
Box 68 leath certifica attending ph	Dhveician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant	7-		23d. Date of delivery	of delivery					
death cer death cer e attendin	-	236. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3( in the past 12 months? 1 ☐ Yes 2 ☐ No	□Ectopic pregnancy □ Other (specify)		Month D	ay Year					
P.O. at the	a d	9 ☐ Unknown			o use contribute to the						
15, P.O. I res that the de signed by the a	3		rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
Cord wrequire been signatured to	7			1 Tes	2 No 3 Probat	JAPAN TOWN					
Fecords, P.O. The law reluires that the tte has been signed by the lags of 2 should be detached.	potoicumo	1	24a. Was an autopsy performed?	prior to comp	utopsy findings available completion of cause of						
The cate to page				1 ☐ Yes 2 🟋	Vo 1 ☐ Yes 2	□ No					
of Vital Rec hysician: The law his certilicate has b I director, page 2 s	á			th (Check only one)	¥	brother's					
Of Phys Phys	F	1 Tes 2 And 1 Inpatient 2 EN Outpatie	of 28c. Injury at	DOA 4 Nursing Home 5 Residence 6 Nother (Specify) nmc 28c. Injury at 28d. Describe how injury occurred							
On Oding		1 (XNatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No								
Division of Vital or Attending Physician: I after death. Director: After this certifica in by the funeral director, p		3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Str	and Number or Rural I	Route Number,					
Div		4 Trumbue Building, etc. (Specify)									
Division of To the Hospital or Attending Phy within 24 hours after death. To the Fundral Director: After thi completely filled in by the funeral		29a. Certifier (Check only (Check only 1) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
the H hin 24 the F		one) and manner stated.  29b. Signature and title of certifier	29c. License number		Date signed (Month, Da						
7 wit.		200 Signature and many states of the states	U5985	/		8, 2007					
6	X'	30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)	3	10	,					
3		Gary Milles, M.D. 8186 Lark Brown Rd.		75							
	State		poels!								
Reg	jistra	JAN 1 9 2007 John D. Ja									

Division or Vital Records. P.O. Box 68760.

Certification: To To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of Cartific Mayacı D63579 January 12, 2007 20% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria J. Taag, M.D. 1936 Kennedy Drive, McLean, Virginia 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

22102

State Registrar



			1 - State of Registrer	Maryland /		ment of H		lental Hy	giene	07	01145
	Physici	an	1. Decedent's Name (First, Middle, Last)	Toroch	035 Ct-	and other		2. Date of De Month	eath Day	Year	3. Time of Death
- A	/Medic	al	4a. Facility Name (If not institution, give street and numl	rn Forst			Landing of Dooth	Janua	-	y 15, 2007 8:3	
4	Examin	ier	Harford Memorial Hospita		4b. City, Town, or Local Havre de			۵		arfor	-G
	Funeral			. Age (In yrs. last b		Under 1 Year	ff Under 24 Hrs.	8. Date of Bi	rth	9. Birtho	ace (State or Foreign
	Director		232-01-3281 <sup>1∑M 2□ F</sup>	87	Yrs.	lonths Days	Hours Min.	(Month, Da Feb. 1	.8,1919	Coun Wes	t Virginia
	and and		Usual Residence of Decedent           10a. State         10b. County	10c. City, Tox	wn or Locat	ion				1	0d. Inside City Limits
	Marylan -f ehow	ţō	Maryland Harford			Aberdee	n				1 ☐ Yes 2 🖾 No
	n the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a c	ralD	3432 Churchville Road			210	01		Unite	d Sta	tes
	er dez	Funeral	Armed Ford	ent Ever in U.S.	13. Was	Decedent of His	spanic Origin? (Spanic American, Puerto	ecify Yes or No Rican, etc.)	o- 14. Rac Blac	e - Americ	
36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dat	TATTAT T	1 🗆	Yes 2₺ No	Specify:		Specif	y: <sub>T.Tl</sub> .	24
0	within 72 hours after death with the Maryland ane hen "naturel", or fleme 23a or 28a-f ehow he Medical Examinar must be notified at	ted	15. Decedent's Education		a. Deceden	's Usual Occupa	tion		16b. Kind of B		ite
215	ithin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	4or 5+)	life. DO	d of work done d NOT use retired)	uring most of work	ng			,
2	led wilygier ther there there	S	12 Years		Mil	Lwright					ustry
anc	d be fi	Be	17. Father's Name (First, Middle, Last)  Okey Straight				18. Mother's Name			ne)	
<i>Oか</i> Maryland 21215-0036	should and Me mark	은	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing A	ddress (Street a	Jane	Forste		State Zin	Code
-	alth a		Judith A. Smith (Daught				ille Road				001
030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mantel Hygiene Information (Health and Mantel Hygiene Information (Heart 27 le marked other then "naturel", or leame 23a or 28a-1 ehov eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition	20b. Place cemete	of Disposition	on (Name of ory or other place	,   [	Date	20c. Location -	City or To	wn, State
W E	Pag ment tant: I		4 □Donation 5 □Other (Specify)				dns. 1/1				er, MD
O E	Depermit Depermit Import Import Import Import Import Import Import		21. Signature of Funeral Service Licensee	2	22. N Di	ame and Address	of Facility Funeral	Home o	of Dunda	lk, I	nc.
N			23a art Frier the trease or mnications that can	used the death. Do	70	22 Wise	Ave. D	undalk.	Maryla		1222 Approximate
	Dhusisian		23a. an1. Enter the sease, or mplications that caushock, or heart fillure. List only one cause on each fillure that cause (Final	ch line.		,			mest,		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)  a  Due to (o)	r as a consequence	ten	a/ /-	ai lung	,			
5	Examiner		Sequentially list conditions	rospps	3/5						
1 3	sit g.e	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events c.	r as a consequence	of):						
(1) n	xecuti and al-tran	хап		r as a consequence	of):						
) / - ) 8760,	icate be executed physicien and sthe burial-transit	dicai E			,						
( ) 0	tificat ng phy as the	ledic	- U.								
Box	eath certiff ettending for use as	an/h		ome of pregnancy th 2 D Fetal deat	h 3∏Ed	opic pregnancy				e of delive	
+ 0.E	t the dea by the el	/sici	1	nt at time of death		her (specify)	· · · <del>-</del> · · · · · ·		Mo	nth	Day Year
A G	res thet thighed by	by Physician/Me	Part II. Other significent conditions contributing to dea	th but not resulting	in the under	riving cause give	n in Part I	23e. Did t	tobacco use cont	ribute to th	e cause of death?
STRAIGH	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	d b				, g g		10	~		ably 4 □Unknown
2000	aw requir ss been s 2 should	plete						24a. Was	an 24b. V	Nere autor	osy findings available
57.	The lav	Completed						auto perfo	ormed //	death?	osy findings available inpletion of cause of 2000 No
ta ta	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death			163	2210
of V	hys his	P.	1 ☐ Yes No Hospitaf: Ing		utpatient		4   Nursing Hor				)
6 c	Attending Physicien: death. ector: After this certifica y the funeral director;	tlon	27. Manner of Death Natural 5 Pending (Month,		Time of Injury	28c. Injury Work M 1 7	at ? es 2 ⊡No	28d. Describe	how injury occurr	ed	
$\omega_i N \dot{b} v R N$ Division of Vital	l or Attendi efter death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place o	f Injury - At home, f				28f. Location (	Street and Numb	er or Rurai	l Route Number,
3 0	tal or At is efter d al Direct ed in by	Certification:	4   Homiciae building	, etc. (Specify)				City or To	wn, State)		
5	Hoepl 4 hou Funer tely fill	Medical	29a. Certifier (Check only one) / Certifying Physicien: To the base and manne	is of examination at	ge, death oc nd/or invest	curred at the time igation, in my opi	a, date and place, a nion, death occurre	and due to the ad at the time,	cause(s) and ma date and place,	nner as sta and due to	ated. the cause(s)
	To the H within 24 To the Fi	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	Month, L	Dey, Year)
	. \		· Nam MIS			D6	0768		1/16/	120	07
	24'		30. Name and address of person who completed cause Moh Ammad & Kh AOA	of death (Item 23a) QMn	(Type, Prin	\$ 7/45/20	JANA A	HAURO 1	10 GOA	OM.	0 21078
	Sta	te	07:11:11	gistrar's Signature	Board	\$ 0	- TIVE T	111016 0	0,0,0	-11 11	- 01010
- 1	Registr	ar	JAN 1 9 2007 120	per the	A CORN	Conta					

			1 - For Stete Registrer	State of M	/larylan		rtment o			d Mental H	ygień Reg. N	_ 0 0	7	01146
	Physici		Decedent's Name (First, Middle, Last	Katherir	ne Mar	ie Sor	rentin	10		2. Date of D Month Janu	D	ay /7 <sup>th</sup>	Year 2007	3. Time of Death
0	/Medio Examir		4a. Facility Name (If not institution, give Upper Chesapeake 1		r)				Location of De		0	c. County		Harford
B	Funeral Director		214-01-4674	x 7. A ☐ M 2☐ F	Age (In yrs. 94	last birthday) Yrs.	If Under 1 \\ Months D	Year Days	If Under 24 Hours N	lin. 8. Date of B (Month, C	ay, Yea	12	Count	ace (State or Foreign ry) yland
340a	with the Maryland a or 28a-f show	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Hart	ord	10c. Cit	y, Town or Lo			allsto	n				od. Inside City Limits 1 ☐ Yes ※※No
0	death with ti		10e. Street and Number 2429 Munford Dr:					047			Un	ited	State	es
7/07	or ite	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marned  3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	s? ₫ No	If	Vas Deceden Yes, specify ☐ Yes 2[x	Cuban	n, Mexican, Pu	(Specify Yes or Nierto Rican, etc.)	lo-		e - America k, White, e	
21215-0086	e filed within 72 hours at Hygiene other than "neturel", vent, the Mudical Ext	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 7 Years		r 5+)	(Give life. (	kind of work o OO NDT use r	nt's Usual Occupation and of work done during most of working D NDT use retired)				Kind of Bu	usiness/Ind	ustry
Vland	2 should be filed within n and Mental Hygiene. 1 ie marked other than 'reumatic event, La My	To Be C	17. Father's Name (First, Middle, Last) Pietro Livolsi					_			ame (First, Middle, Maiden Surname)			
e, Mar	1 and 2 sho Health and Dm 27 ie m ther traum		Rosemary A. Bongiorno 24 20a, Method of Disposition 20b. Place of Di							n, M				
800 4 ( Baltimore	permit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked eny injury or other traumatic evonce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State cemetery, crematory or other place)								Ва	Baltimore, Maryland		Maryland
7) 8.	Depa Impo eny ii		23a. Part1. Enter the disease, or comp		ed the death	7	922 Wi	se	Ave.	Dundalk,	Mar		21:	C • 222 Approximate
68760,	Physician /Medical Examiner  the prival-transit	edical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Syste Doga to (or a b. Bill	mic as a consequence of the consequence	uence of):	Prec	fon	j Bs onea	bonse S	fno	fore		Interval Between Onset and Death one Week
Box.	Attending Physicien: The law requires that the death certificate robath.  ector: After this certificate has been signed by the attending physy the funeral director, page 2 should be detached for use as the i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 PSNo 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic pregr Other (special					23d. Dat Mor	e of deliver	y Day Year
rds, P.C	v requires that the bear signed by should be detact	þ	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the un	derlying caus	se give	n in Part I.			use contr		e cause of death?
لامباب المرابعة المرابعة المرابعة المرابعة Division of Vital Records, P.O	The law requipele has been page 2 should	Completed								24a. Wa auto per 1 🗆 Yes	opsy formed?		prior to com leath?	sy findings available pletion of cause of
f Vita	ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	tient 2	ER/Outpatien	3 □ DOA	Other		Death (Check only		6 □Oth	er (Snecify	)
sion o	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of In (Month, D	njury Day Year)	28b. Time of Injury	28c.			28d. Describe	how inj	ury occurr	ed	
Divi	2 2 2 2		4 Homicide determined	28e. Place of I building,						City or To	own, Sta	te)		Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medicai	(Check only 2 Medical Exam	and manner	of examina stated.	tion and/or inv	estigation, in	my opi	inion, death o	ccurred at the time	, date ar	nd place, a	and due to	the cause(s)
	r > ⊢ ō		30. Name and address of person who co	ompleted cause of	I death /lia-	23a) /Tuan	De	209	5660	7	Ton	iring	17 1	2007
	6		JOSEPH ANG 20  31. Date filed (Month, Day, Year)	Swit 205	strar's Signa	2 S.	ATWO	D	Rd, 1	BELAS	R,	me	2	1014.
	Sta	ite	VAN 1 9 2007	See A. A. A.	A Signa	wester								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) РМ **Physician** Mary Peterson Schwenker 15, 2007 1:15 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 12, 1922

9. Birthplace (State Country)
Minnesota 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1 ☐ M 2 🗗 F 84 Director 214-18-9801 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 23a or 28e-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 United States 8909 Kensington Parkway permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or Items 23a any injury or other traumatic avent, the Madical Examinational once. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christine Milland Harold Hermanson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christine M. Hart/Daughter 6925 Armat Drive, Bethesda, Maryland 20817 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Parklawn Memorial January 19, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 21. Signatured Funeral Service Licensee

MO0198

22. Name and Address of Facility
Robert A. Pumphrey
Robert A. Pumphrey
Funeral Home
Chase Inc.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate
Immediate Cause (Final Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Park Immediate Cause (Final **Physician** Sepsis Syndrome disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Right Lower Lobe Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending | 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2X No Day 4□Pregnant at time of death 5 Other (specify) be detached Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2√2 No 3 ☐ Probably 4 ☐ Unknown Urinary Tract Infection, Clostridium Difficile Colitis Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus Brain Metastases autopsy performed? 1 Yes 2 No Hypertension Division of Vital el or Attending Physician: 3 s efter death. sl Director: After this certifice ad in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 

Inpatient 2 □ EP/Outpatient 3 □ DOA 1 ☐ Yes 2 🙀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 | Yes 2 | No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours eft To the Funeral DI 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4mam In D53367 January 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, M.D. 9801 Georgia Avenue, Silver Spring, Maryland 32. Registrer's Signature 31. Date filed (Month, Day, Year) State JAN 1 9 2007 CARLARIA Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1	For State Registrar	State of Maryland		rtment of F			jiene leg. No 200	7 01148
300 m	, - <del>1</del>		Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physicia /Medic	al-	Ramaswamy Savith					Januar		
	Examin	er	4a. Facility Name (If not institution, give str				r Location of Deat	1	4c. County of	
			11112 Candlelight  5. Social Security Number   6. Sex	7. Age (In yrs. la	ast birthday)	Potoma If Under 1 Year	If Under 24 Hrs.		Montg	9. Birthplace (State or Foreign
	Funeral Director			и 2ДF 92	2 Yrs.	Months Days	Hours Min.	Dec. 26	5, 1914	Country) India
مرافعود	pu ,	H	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	cation				10d. Inside City Limits
	laryla shov			′	,					1 ☐ Yes 2 No
	the N 28a-f notifi	Director	Maryland   Montgomery  10e. Street and Number	Po	tomac	10f. Zip Code			10g. Citizen of Wh	at Country?
	3a or	Ö	11112 Candlelight I	lane		20854-	2760		India	
	death	Funeral		. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Black,	American Indian, White, etc.
98	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give		1 □ Yes 2 🔯 No			Specify:	Asian Indian
Ö	hours tural	q pa	15. Decedent's Educa	Year or Dates:	16a. Deced	ient's Usual Occup	pation		16b. Kind of Busi	
21215-0036	iin 72 • <b>n "na</b> Medic	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. l	kind of work done DO NOT use retire	during most of wo d)	rking		
212	d with giene er tha , the I	Jom J	Elementary/occonducty (6 12)	2		Teacher				School
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				1 1		Maiden Surname)	)
<del>Z</del> a	d Men narke	P	Ramaswamy Iyer  19a. Informant's Name/Relationship (Type	Print)	10h Mailir	na Addraes (Streat		nani Rama	SWAMV er, City or Town, Si	tate Zin Code)
Maryland	d 2 st th and th snor 7 is n traur		Kalpathi Venkatrama	•					-	land 20854-2760
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	l ý	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other pla	i _	Date 20,	20c. Location - C	
OE I	Page: lent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State MOTA	tgomer	um. The.	200	7	Bethesda	, Maryland
Baltimore,	permit. Departmimporta any inju	1	21. Signa Rem Funeral Service Ligenses		22 R c	2. Name and Addre	ess of Facility RO	bert A.	Pumphrey	Funeral Home/ sconsin Avenue
<u> </u>			Jun 3 (E)		803 Be	ethesda,	Maryland	20814-	3501	
90			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cause on each line.	,		ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Freum		-				1 day
	/Medical Examiner			Due to (or as a consequ	uence or):					U
	*** **	ř	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
3	cuted nd ransit	Examiner	that initiated events							
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	E	resulting in death) Last	Due to (or as a consequ	uence of):					
387	cate b physic	edical	d.							
Box 6	death certific attending pl	/Me	IF FEMALE: 23b, Was decedent pregnant 23	c. If yes, outcome pf pregna					23d. Date	of delivery
m.	death e atter d for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal		⊒Ectopic pregnand ☐ Other <i>(specify)</i> _	У		Mont	h Day Year
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S,	ires that signed t	by	Part II. Other significant conditions cont	ributing to death but not resu _ Mala:tritio		nderlying cause gi	ven in Part I.	23e. Did to		oute to the cause of death?  B□ Probably 4 ሺ Unknown
0.00	w requir been s	eted	H +	27 6 27 27 27						
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Vital	i <b>cian:</b> Th certificate rector, pag	e Co	25. Was case referred to medical				26 Place of De	1  Yes ath (Check only o	25	Yes 2□ No
Š	S S :=	O B	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ot	har		dence 6 □Other	(Specify)
10 L	ding Phy I. After thi funeral (	T:U	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju	ıry at ork?	28d. Describe	now injury occurre	d
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2 □No	001 1 11 11	2	D I D I All b
Division	- 0 <u>-</u> -	Certification:	4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specifi	y)	reet, ractory, office		City or Tow		r or Rural Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in			cian: To the best of my kno						
	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	Medical	(Check only 2 Medical Examin one)	er: On the basis of examina and manner stated.	tion and/or ir	rvestigation, in my	opinion, death occ	curred at the time,	date and place, a	nd due to the cause(s)
	To the within 2.	Ň	29b. Signature and title of certifier	( )		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
			) Ciaco I	-wi			7891		January	16, 2007
-	2		30. Name and address of person who cor				#110 ==	7		1 00000
		ate	Amit Rajvanshi, l 31. Date filed (Month, Day, Year)	M.D. 9801 Ge 32. Registrar's Signa	orgia	Avenue,	#118, Si	<u>tver Spr</u>	ing, Mar	yland 20902
	Regist		IAN 1 9 2007	32. Registrar's Signa	Gorne	, B				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 6 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NOTEHOU ind 17 5. Social Security Number Date of Birth Birthplace Country) Age (In vrs. last birthday (State or Foreign **Funeral** Days Hours 11/18/1920 Months 1□M 2□F MD 86 218-07-0568 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla peperment of Health and Mental Hygiene. Internet of Health and Mental Hygiene Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No OWINGS MILLS BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21117 3420 ASSOCIATED WAY #209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene.

Is marked other than "natural", or ite 1 □ Never Married 2 □ Married WHITE 1 ☐ Yes 2 💢 No Saltimore, Maryland 21215-0036 Specify δ 3 ☐ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANICURIST COSMETOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PERKAL BESSIE MOSGIN ISIDORE ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
125 FASTFRN PARKWAY #6-F BROOKLYN, NY 11238 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health a LARRY SCHWARTZ / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State REISTERSTOWN, MD BALTIMORE HEBREW CEM | 01/18/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt Le-8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties of the pr use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy performed Yes 2 1∐ Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation ours after death.

neral Director; Air 1 🗌 Yes 2 🗆 No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signature

Year)

9 2007

filed (Month, Day,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deal 1. Decedent's Name (First, Middle, Last) **Physician** 01 6 2007 eborah /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Bayvier 8. Date of Birth (Month, Day, Yea JULY 19, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 218-64-4257 1 ☐ M 2 ☐ F Yrs. 50 MD. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show 1 X Yes 2 □ No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Director BALTIMORE MD. N/A 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 21224 243 S. ROBINSON ST. filed within 72 hours after death within Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9TH College (1-4or 5+) HOME MAKER OWN HOME and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET MOSES JOHN WALKER, JR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 243 S. ROBINSON STREET, BALTIMORE, MARYLAND 21224 JENNIFER McCAULEY/DAUGHTER 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1/20/2007 PARKWOOD CEMETERY BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Poter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** netastatio Vears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. End of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 100 Hospital or Attending Physician: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ... N 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a er death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Hylan Bry Me- Circle Baltimine Mozials

completed cause of death (Item 23a) (Type, Print)

MO 5. 32. jegistrar's Signature

2007

07-00211		Please Type or Print in Black Indelible Ink. Ensure All Copie		gible.	
Mackenzie Jeanir	j	1- For State Certificate of Death Registrar Certificate of Death	, 0	Reg No 200	7 011
Physician Medical Examin	-	1. Decedent's Name (First, Middle,Last)  MacKenzie Jeanine Bowman Stewart	2. Date of Dea Month January 8		3 Time of Death 0731 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  7601 Gaither Road  Sykesville	h	4c. County of Dea	th
Funeral Director		5. Social Security Number 2 1 9 . 3 9 . 6 6 7 3 6. Sex 1 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hr. Months Days Hours Mir		rth(MM/DD/YYYY) 9. B / 1 9 9 3 Fore	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d Inside City Limit
ınd show a	٦	MD Carroll Sykesville			1 Yes 2 X XN
the Maryla a or 28a-f		10e. Street and Number 7601 Gaither Rd. 10f. Zip Code		10g. Citizen of What Col USA	untry?
death with or items 23 must be uo	Funeral	11. Marital Status  1	pecify Yes or No Rican, etc.)	White, etc	erican Indian, Black,
s after rral",	≥	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		Specify	hite
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be notified at once.	ompleted	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  Rever worked	work done ired)	never w	•
5-0036 Iled within 7 Hygiene J other than the Medica	ပေ			Maiden Surname)	
2121 uld be fil Mental B marked c event,	o Be	Graham Hamilton Stewart  19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or I		Jane Bow	
MD 2 d 2 shou lth and N n 27 is n	- 1	(or our distribution of			
re, Nad I and I and I healt!		20a Method of Disposition 20b Place of Disposition (Name of compton)	Date	20c. Location - City o	r Town, State
Baltimore, bernit. Pages I an Department of Hee important: If ites njury or other tr		1 X Burial 2 Cremation 3 Removal from State Zion Church Cemetery 4 Ponation 5 Other Specify:	1/13/0	7 Balto,	MD
Balt permit. Departi Import injury		21. Signature of Funeral Service Licensee  22. Name and Address of Facility S 1 3 3 8 7 1 0 1 d C 0 1 umb	ia Pik	e, MD 210	e, P.A. 43
Physician /Medical		239. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.		rest, shock, or heart	Approximate Interva Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Acute bronchopneumonia complicating cerebral pue to (or as a consequence of):	palsy	· · · · · · · · · · · · · · · · · · ·	Death
	ē	Sequentially list conditions, If any like fing to manufact.  Due to (or as a noneiguenes of):	_		
	⊑	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			-
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0, be expected by the expectation of the expectatio	edical	X UNPENDED AMENDED 4.27, perME, g865, 3/2/07 Tt			
vision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be execut there death in Viretors. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial—trained.	≥	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy  4 Pregnant at time of death  5 Other (Specify)	ancy	23d. Date of deliver Month	Day Year
. Bo he deal y the at hed for	y y	1 Yes 2 V No 9 Unknown 9 Unknown			
S, P.O.	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bbacco use contribute to	
vision of Vital Records, or Attending Physician: The law requirn Mer death Director: After this certificate has been sin by the funeral director, page 2 should be seen in the funeral director.	ompieted		24a. Was autop perfor	psy prior to death?	utopsy findings availabl completion of cause of es 2 No
tal R ian: T	∟ د	25. Was case referred to medical examiner?			2 110
4 4 5 E F	اٍ ٥	1 Yes 2 No The Inpatient 2 ER/Outpatient 3 DOA Other Nursin		Residence 6 🗸 Othe	r: Scene
on of or or or or or or or or or or or or or	HOU	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	∠8a. Describe l	now injury occurred	
ivisior I or Attend after death Director:	u ا	2 Accident Investigation 3 Suicide 6 Could not be Could n	28f Location (S	Street and Number or Ru	ural Route Number, City

To the Hospital within 24 hours a To the Funeral Completely filled Medical Cer

						performed? 1 ✓ Yes 2 No	death?	2 No
. Was case referred to medical				26.Place of De	ath (Check	only one)		
examiner? 1 ✓ Yes 2 No	Hospit	tal: 1 Inpatient 2	ER/Outpatient 3	ng Home 5 Residence	6 Other: Scen	e		
. Manner of Death	2		28b. Time of Injury	28c Injury at W	/ork?	28d. Describe how injury of	occurred	
X Natural 5 Pend	ina	(Month, Day, Year)		1 Yes 2	No			
Accident Inves	tigation							
Suicide 6 Could	not be	28e. Place of Injury - At ho	ome, farm, street, factor	ry, office building	g, etc.	28f Location (Street and I	Number or Rural Rou	ite Number, City
deter	mined	(Specify)				or Town, State)		

111 Penn Street, Baltimore, MD 21201

29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie

ele

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 8, 2007

30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Tasha Greenberg MD.

State 31. Date filed (Month, Day, Year) JAN 1 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #16b perFH, G863m 1/19/07 TT

Continue of Department of Health and Mental Hygiene

1- Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 1910 Tanvery Latinda Tates 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner x 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Date of Birth (Manth, Day) **Funeral** Months Days Hours 1 M 2 F **Director** 263-41-121 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Funeral Director atonsvil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Num Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be 2122 0 ac Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) lear 17. Father's Name (First, Middle, Last Name (First, Middle, Maiden Surname Be 힏 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition or other place. permit. Pages Department of I Important: If it any Injury or o cemetery, cremate 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-22-2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera 2113 mo Kan 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PSEUNDMEN PAUL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Anumen 14 Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 

✓ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No s certificate has birector, page 2 s autopsy performed 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After to in by the funera Certification: (Month, Day 5 Pending investigation 1. Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours a To the Funeral I 0

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Muce

JAN 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

21133

and manner stated.

m.0

32. Registrar's Signature

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5310

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

George W. Taglia	1	- For State	State of	Marylan	d / Departn <i>Certifi</i> e		Health Death	and	Menta	al Hygie	ene Reg	No		
Physicia		teqistrar  1. Decedent's Name (First,	Middle,Last)				_				ate of Death	-	<del>200</del>	3 Time of Death
Medical Examin		George W. 7	agliaf	erre						Ja	onth [ nuary 14,	Day 2007	Year	1425 hrs
agent of the same		4a. Facility Name (if not ins					4b. City, To		ocation of	Death			unty of Death	1
<i>)</i>		Western Maryland					Cumbe		Lieus Isra	0411 10 1	Date of Birth		gany	thplace (State or
Funeral Director	ľ	5. Social Security Number 220–32–3842	6 Sex	2 F	Age (In yrs. last b	oirthday) Yrs	If Under Months	Days	If Under : Hours	1.4	ept 10	,	Foreig	
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and F show	<u>.</u>		11egan	ıy		Cumb	erlan							1 Yes 2 X No
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 14210 Cunn:	ingham	Drive			10f. Zip (	Code	21.	502	10g	j. Citizen	of What Cou USA	ntry?
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ier de		3 Widowed 4	Divorced If	112 Yes Yes, Give Year	<sup>2</sup> 53-61	1	Yes 2	Νο	specify:			Spe	ecify wh	ite
ours af	d by	15. Decedent's Education		r Dates: highest grade	completed) 16		nt's Usual 0			nd of work o	done	16b. Kınd	of Business/	Industry
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215- be filed ntal Hyg rked of		Ralph Tag		re						,	Maiers		,	
212 buld bould bi Meni		19a. Informant's Name/Rel			1	19b Mailin	g Address	(Street					r Town, State	e, Zip Code)
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AMENDED    AMENDED   AMEND														
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certif	ying Physicia	n: To the best	of my knowledge,	death occ	urred at the	time, da	ite and pla	ce, and due	to the cause	e(s) and n	nanner as sta	ited
To the within To the comple	Medical	one) 2 Medic	al Examiner:	on the basis of and manner sta	f examination and/ ated	or investig				curred at the	time, date a			
£ 5 E 5	ž	29b. Signature and title of	certifier				290		e number				,	onth, Day, Year)
			/					O.C.I	vI.∟.			Janua	iry 15, 200	) (
		30. Name and address of Mary G. Ripple	,		e of death (Item 23 ledical Examil		I1 Penn	Street	, Baltimo	ore, MD 2	21201			
S	tate				bistrar's Signature	- 5								
Regis		JAN	1 9 20	107 /	alus B	A	arles		-		_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician bruary /7, acc. Ounty of Death 20:46 PM TUNKINS Annie ERa /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cit Hospital of Baltimore timore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08 27 11913 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1□ M 2 1 219-10-7203 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygleine. Internet of Health and Mental Hygleine in Tatural!" or items 23a or 28a-f show Important: If Item 27 is marked other than "natural!" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Baltimore Director MT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6636 Eberle Drive 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Ho
If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never\_Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 Specify: BIK þ 3 \ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) IURSES Health Care A55+. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Boulah Wax Wax ဂ George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6332 Byidsell (daagutus) AriaaL Drive ithonia Ga. atient Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemeter Battimore, MD 1/19/07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Green
Vaughn C Green
5151 Batto. Nat'l Pike Greene Funeral SER 21. Signature of Funeral Service Licensee Bulti. MD. MO 140 21229 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shy pk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme wite Cause (Final disease or condition resulting in death) Physician Annacic Brain /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if the least sequential sequence is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed oumadin and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hin 24 hours af the Funeral D mpletely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier e who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Fatt Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ELIZABETH L. TAYLOR 17, 2007 JANUARY 5:36 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8676 OAK ROAD PARKVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/13/1925 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 220-18-7807 Director 81 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f sh Injury or other traumatic event, <u>the Medical Examiner must be notified</u> MD BALTIMORE 1 ☐ Yes 2 XNo Director PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8676 OAK ROAD 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DEFENSE CONTRACTING Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If them 27 Is marked other the any Injury or other treasment. AUDIT AGENCY STENOGRAPHER 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS E. LAMB THERESA FEEHLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD J. TAYLOR, JR./HUSBAND 8676 OAK ROAD BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEM. 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2007 PARKVILLE. MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD riv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only ne causa of each line. Approximate Interval Between Onset and Death **Physician** Mycardial In Fouction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-trans Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death
9□Unknown Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2☑ No or Vital 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 25 No ၉ 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: **Division** 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 032543

State Registrar MANC
31. Date filed (Month, Day, Year)

STUDING 6 6

32. Registrar's Signature

IAN 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 13, 2007 7:50 Рм **Physician** Jean W. Tolbert /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Montgomery Hospice Casey House If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 24, 1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🛛 F Washington, D.C. 89 217-07-0488 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c, City, Town or Location 1 ☑ Yes 2 ☐ No Rockville Director Marvland Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20851 1704 Henry Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates: Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Company Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvina E. Cowell Frederick R. Waterholter မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1704 Henry Road, Rockville, Maryland 20851 Barbara Watkins/Daughter January 19, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Parklawn Memorial Parklawn Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service Licensee M00198 < c 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physiclan/Medical the as 1 IF FEMALE nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🔯 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown ate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 M Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No certificate has 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 Z No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

 $O_{j'}$ 

31. Date filed (Month, Day, Year) State

Cynthia M. Williams, D.O. 32. Registrar's Signature

Silliams Do

JAN 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams, D.O. 6001 Muncaster Mill Road, Rockville, Maryland 20855

H0058032

Registrar

)/-00391		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
Kibwa Wilkens-V		1. For State	107 0115
	F	Registrar	3 Time of Death
Physicia		Month Day Year	
Medical Exami			
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Sinai Hospital  Baltimore	'A
			Birthplace (State or
Funeral		Months Days Hours Min	Foreign
Director		240-31-7188 1 M 2 F 27 Yrs. World's Days 1881 Nov 8, 1979	Country) NC
*		Usual Residence of Decedent  10a State 10b County 10c. City, Town or Location	10d Inside City Limits
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and sho	ō	NC Young sville	
viary	ect	10e. Street and Number 10f. Zip Code 10g. Citizen of What	at Country?
with the Maryland ns 23a or 28a-f she	Funeral Director	5712 Jack Jones Rd 27596 USA	
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s l ar of Hea of Hea		20a. Method of Disposition  20b. Place of Disposition (Name of Ametery, Cremation 3 Removal from State Crematory or other place)	4
Page Page sent c		4 Donation 5 Other Specify Corinth Church Can. 1/20/07 Youras	Ville NC
Baltimore, permit Pages I at Department of He Important: If ite	ı	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charman - Harif	s Funeral Home
E Pe D		Jarry Hams 5240 Reisterstown Bd Baltimore	- Md 21215
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heafailure. List only one cause on each line.	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a Multiple injuries	Death
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be exactler this certificate has been signed by the attending physician functal director, page 2 should be detached for use as the burial-	led	AMENDED #1,27,28a-f, perME, g865, 3/12/07 TT  23d If yes, outcome of pregnancy 23d Date of	delivery
68760, certificate be nding physic se as the bur	ian/Mec	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month	Day Year
x 6 h cer tendi	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
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death death	ati	Accident Accident Investigation Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 1997)	
Division Ital or Attendius after death	ertification:	28e Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number of Town, State) 5810    28e Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number of Town, State) 5810    28e Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number of Town, State) 5810    28f. Location (Street and Number of Town, State)	Reisterstown Road
Ospital hours nueral y filled	Se		
Division of Vital I  The Hospital or Attending Physiciau: Fin 24 hours after death The Funeral Director: After this certifing in the Funeral director.	I —	29a. Certifier 1     Certifying Physician: To the hest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner	as stated
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medica	and manner stated.	
F × F 0	ž		ed (Month, Day, Year)
1		Forste Dearford O.C.M.E. January 14	, 2007
		30. Name and address of person who completed caus of death (Item 23a)	
P	-	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	State	te 31. Date filed (Month, Day Year) 32. Legistrar's Signatule	
Regi	strai		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Attended to the James Watson State of Maryland / Department of Health and Mental Hygiene									
nic damai **	atou	State of Maryland / Department of Health and Mental H  1-For State  Certificate of Death	ygiene	2001	01158				
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)	Reg	g. No	3. Time of Death				
edical Exam		DANTE JAMAL WATSON		Day Year	2211 hrs				
)		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	th				
		Johns Hopkins Hospital Baltimore		N	IA				
Funeral Director		5. Social Security Number 6. Sex 7. Äge (In yrs, last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	_	(MM/DD/YYYY) 9. B Fore	an				
Director		216-08-2396 1XM 2 F 21 Yrs.	APRIL 1	3,1985 0	ountry) MARYLAW				
ń		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location		/	10d Inside City Limits				
d now a		NACULAIA NA	0 -	1	1 X Yes 2 No				
arylan 8a-f sl	cto	10e. Street and Number  10f. Zip Code	10	g Citizen of What Co					
ith the Maryland 23a or 28a-f show any notified at once.	Dire	2219 FIFETUMA AVE 40TO 1 212 1	$u \mid '$	116	0				
eath with the items 23a	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S)		14. Race - Ame	rican Indian, Black,				
death or iter	nu:	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.					
s after ral", o	by F	3 Widowed 4 Divorced of Personal 1 Yes 2 X No specify:	_	Specify: B	ACK				
2 hours afte "natural", Examiner	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a Decedent's Usual Occupation (Give kind of votation) during most of working life. DO NOT use retired to the control of the contr		16b. Kind of Business	/Industry				
36 hin 72 e. than	ple			0-11-	CF				
5-0036 led within 7: Hygiene. other than	Completed	17. Father's Name (First, Middle, Last) (UNKNC(UN)) 18. Mother's Name	e (First, Middle, M		:GE				
21215 uld be file Mental H marked o	Be	JUNE	= V V	ETTE	WATSON				
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene, 11. If them 27 is marked other than 'st.	ဥ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R	Rural Route Numb	er, City or Town, Stat	e, Zip Code)				
re, MD ss 1 and 2 sho of Health and If item 27 is		MICHELE C. WRIGHT (AUNT) 2370 LEXINGTON AVE. S.	4PT, 122, M.	ENDOTA HIGH	TS. MINN, 55120				
ore, es l ai of Hei If ite her tr		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date /	20c. Location - City o	r Tofvn, State				
Baltimore, permit Pages I an Department of Hea Important: If iten			20-07	WOODLAD	UN, MA				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21 Signature of Funeral Service Licensee 22. Name and Address of Facility B	ROWNJI	R. FUNERA	+L HOME				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	TAVE . A		MD 21217 Approximate Interval				
/Medical		failure. List only one cause on each line.	. roop and a grant	sk, driedk, driedk	Between Onset and Death				
<b>√Examiner</b>		Immediate Cause (Final disease or condition resulting in death)  a. Stab Wound To The Neck  Due to (or as a consequence of):	_						
		Sequentially list conditions, b							
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
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executed an and al - transit	ical E	d.			<u> </u>				
B 2 4 6		UNPENDED AMENDED			_				
8760, ifficate be ng physicials the buria	n/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancv	23d Date of deliver Month	y Day Year				
Box 68760, death certificate be he attending physic of for use as the bur	icia	past 12 months?  4 Pregnant at time of 5 Other (Specify)							
Bo he dea the a	Physician/Med	9 Unknown							
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Funeral Director: After this certificate has been signed by the attending physicially filled in by the funeral director, page 2 should be detached for use as the buri	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	the cause of death?				
ords, P.C w requires that is been signed the	ted		24a Wasar		utopsy findings available				
COFC law re has be	Completed		autopsy	y prior to	completion of cause of				
tal Recian: The	S		1 ✓ Yes 2		es 2 No				
of Vital Records, ag Physician: The law require. ther this certificate has been si neral director, page 2 should b	Be	25. Was case referred to medical examiner?  1 ✓ Vas 2 No Other Nursin 2 ER/Outpatient 3 DOA Other Nursin Nursin 2 No Nursin 2 Nursin 2 Nursin 2 Nursin 2 Nursin 3 Nu							
of Ving Physical Character of the Charac	<u>1</u>	1 V Yes 2 No Inputer 2 Endougation 3 DOA 4 North		esidence 6 Othe	r: 				
ion (tending eath.	Certification:	1 Natural 5 Pending FOUND: 1 Yes 2 No	Subject was						
Division ospital or Attendia hours after death.	fica	2 Accident Investigation Jan 15, 2007 1222 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St	reet and Number or Ri	ural Route Number, City				
Div pital o ours af ieral D	erti	Odloide State in the	or Town, Sta 2209 Fleetwood	ite) d Avenue, Baltimore	e, MD				
Hosp 24 ho Fun etely f		29a. Certifier (Check only)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and							
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated	t the time, date ar	nd place, and due to th	ne cause(s)				
	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo					
		Kamely ruthall, ml) O.C.M.E.		January 18, 200	/				
19		30 Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201						
9	ate	31. Date filed (Month, Day Year) 32 Registrar's Signature							
Regis		JAN 1 9 2007 Beauty S. Sparter							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ROBERT WALLS 3:36 PM AN 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A OF MARYLAND HOSPITAL UNIVERSITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) 8. Date of Birth (Month, Day, Year) Funeral 215-44-0766 Director nasylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. the Medical Eyamina made and a show any Injury or other traumatic event. 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 Washington Funeral Was Decedent Ever in U.S Armed Forces?, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restauran (a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be H. Walls harles Margarite Stafford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kichard Walls 1201 Washington Blvd MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State January 14, 2007 Hancver, MD 4 Donation 5 ☐ Other (Specify) Ancetany GIF-ts Registry 21. Signature of Fune al Service I 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suit P. Hanover, MD21076 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia /Medical Due to (or as a consequence of): Examiner tailire Sequentially list conditions, if any leading to immediate Examine if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-trans Renal tailure Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? Yes 2 No 1∐ Yes funeral director. 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ine St

Baltman, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** TAN2007 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death institution, give street and number Examiner Hartoc If Under 8. Date of Birth (Month, Day) Year) Funeral 1 □ M 2 F Min. Days Hours Yrs. MARYLAND 6/10/ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Har 10g. Citizen of What Country? 10e. Street and Number 21013 DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) 3altimore, Maryland 2121 College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Freeland New port De., Forest Hill, MO ZIUSO 21. Signature of Funeral Service Licerse Evans Funeral Chapol+ Cremation Solvices-Bel Air complications that cause the reath. Do not enter the mode of dying, such as cardial or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Fina disease or condition resulting in death) Cardiovascular herosclerotic **Physician** /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Mellitus sia betes buriat-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 1 Inpatient Medical Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence D, White MD 615 W. D 615 W. MacPhail #206 Bel Ar MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MARGARET WINAKER 15, JANUARY 2007 8:10 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Date of Birth (Month, Day, Ye 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Days A15-03-522 Usual Residence of Decedent Director with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28s-f show other traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Decedent 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ 3 Widowed 4 □ Divorced White "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homomake 17. Father's Name (First, Middle, Last), 18. Mother's Name (First, Middle, Maiden Surname, Pages 1 and 2 should be 1 nent of Health and Mental I ent; if item 27 is marked of 2 19b. Mailing Address (Street and Number or Rural Roun Number, Chr. or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of 20a. Method of Disposition

1 Burial 2 Cremation 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: if ite any injury or ot 2005 3 Removal from State Himore Hebrew 4 ☐ Donation 5 ☐ Other (Specify) om 21. Signature of Funeral Service Hill, MD . MUNOLA Evans runeial REPUICES-BEITHIR 23a. Part1. Enter the disea + . . . comb cations that shock, or heart failure. List on / or e cause on Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardial or respiratory arrest, Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospitei or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit ed by the attending physicien and detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Tyes 2√ No 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Other 1 ☐ Yes 2 ☐ No Certification: To 1 fnpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury Natural 5 Pending 1 Tes 2 No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 15. Certifying Physician: To the bast of my knowledge, Seath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 033532 JAnuary 16, 2007 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) DR. DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

JAN 1 9

2007

82. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla	•	artment of Hertificate of L		ntal Hygler Reg. l	2007	01162
ı	Physici		Decedent's Name (First, Middle, L     BULAH	ast) DPAL WHISEN	ANT			Date of Death Month January	<sup>Day</sup> l 4 , 2007	3. Time of Death 7:00 A M
	/Medio Examir		4a. Facility Name (If not institution, gr 6008 Glenoak Av			4b. City, Town, or B	Location of Death altimore		4c. County of Death	
1	Funeral Director		236-09-6816	Sex 1□M 2໘F 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. O	Date of Birth (Month, Day Ye.	9. Birthp Court West	place (State or Foreign May) Irginia
	death with the Maryland me 23e or 28e-f ehow rount to natified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD	10c.	City, Town or Lo	Baltim	ore		1	Od. Inside City Limits  X☐Yes 2☐No
	h with the 13e or 28e	ai Director	10e. Street and Number 6008 Glenoak	Avenue		10f. Zip Code	1214	10g.	Citizen of What Cour	ntry?
920	hours after deat turel', or Iteme 2	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ Xio	spanic Origin? (Specif n, Mexican, Puerto Rio Specify:	y Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036	"na"	Completed	15. Decedent's Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)		dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of working	1	. Kind of Business/In- ternationa	•
land 2	id be filed ental Hygis ked other ic event, II	To Be Co	12 17. Father's Name (First, Middle, Las Moses Andrev	· _	OII		18. Mother's Name (F	irst, Middle, Maio a Craft	len Sumame)	
	and and sm	-	19a. Informant's Name/Relationship William Whisenan		19b. Mailir 6008	ng Address (Street a Glenoak A	nd Number or Rural F venue-Balt	oute Number, Cit imore, Ma	y or Town, State, Zio ryland 21	214
Baltimore,	S to I		20a. Method of Disposition  1  Burial 2  Cremation 3  Other (Special Control C	□Removal from State Ga	Place of Disponder Cemet	for alth	Date 17-	Do	Location - City or To psedale, Ma	
Balt	permit. Page Depertment of Important: if any Injury or ance.		21. Signatur of Funeral Service Lice	7: Fudd	22 E A	Name and Address VANS FUNE ND CREMAT	RAL CHAPET TON SERVIC	正ろ	Marford Ro	ad land 21234
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	a. Due to (or as a cons	aguence of):	()	n, such as cardiac or r wia Failu			Approximate Interval Between Onset and Death
68760, 6	icate be executed physicien and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	c. Due to (or as a cons	entra					
P.O. Box 6	The law requires that the death certificate be executed ate been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of prec 1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
	quires that in signed b uld be deta	ed by PI	Part II. Other significant conditions	contributing to death but not r	resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
Division of Vital Records,		Completed						24a. Was an autopsy performed	? death?	psy findings available inpletion of cause of
/ita	certificer ector, p	Be	25. Was case referred to medical examiner?	Hamital.		Tou	26. Place of Death (C	Check only one)		
on of	ing Phys Viter this Ineral di	tion; To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigativ	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatien 28b. Time of Injury	f 28c. Injury Work	4   Nuising Home	5 Residence  1. Describe how in	6 ☐Other (Specificial Specificial Specifi	/)
Divisi		Certification;	2 Accident investigation 3 Suicide 6 Could not determine	be and Diese of Injury A	t home, farm, str cify)			Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	To the Hospitel or Atta within 24 hours after de To the Funeral Directo completely filled in by th	Medical (	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of my kaminer: On the basis of examinand manner stated.	ination and/or in	vestigation, in my op	inion, death occurred	at the time, date a	and place, and due to	the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier			29c. License	number	29d. I	Date signed (Month,	Day, Year)
	í		) Mohadhi a			1000	104749		01/15/20	104.
	Sta Regist		30. Name and address of person who Rashid Mohi U 31. Date filed (Month, Day, Year)  JAN 19	o completed cause of death (III)  32 Registrar's Sig	tem 23a) (Type,	SIER LOAC	1-61en L	SUNIE,	Maylana	007 ·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1 Decedent's Name (First, Middle, Last) Day 746PM Physician January 14,2007 Audrey Brown Williams /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Ba Himore Hospital Baltimore Birthplace (State or Foreign
 Country) If Under 1 Year | If Under 24 Hrs. Date of Birth 12/26/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖫 🗲 300-22-3680 Director Usual Residence of Decedent 10d. Inside City Limits 10b: County 10c. City. Town or Location 10a State Items 23a or 28a-f show s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. I Health and Mental Hygiene titem 2.3 is marked other then "natural", or Items 2.3s or 28s-f show other traumatic event, I is Muclical Examinar must be nutited at other traumatic event, 1 Yes 2 No MD Baltimore City Baltimore Director 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number USA 21215 4601 Pallmall Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Yo Specify Specify: Black If Yes, Give Year or Dates: Completed by 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maid Elementary/Secondary (0-12) College (1-4or 5+) House Keeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard H. Hill Be Martha Venable Pages 1 and 2 should be nent of Health and Mental int: If item 27 Is marked o ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4006 S. Williams Street Amarillo, TX 79118 19a. Informant's Name/Relationship (Type, Print)
Jospeh A. Williams/Son permit. Pages 1 and 2 is Department of Health ar Important; if item 27 is any injury or other trau once. Date 18 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2 Namati Addes and a Tuneral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 exulu- M01443 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) 3days Pneumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off-Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t be def Completed by 2 No Mell 3 Probably 4 □Unknown 1 Yes should should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes certificate or Attending Physician: After this certification 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 15 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Magner of Death 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Thomicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of centifier 0063322

State Registrar

B. Iliams

YNU SZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOH

32. Registrar's Signature

MANDER

31. Date liled (Month, Day, Year)

164 State of Maryland / Department of Health and Mental Hygiene \( \) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:56 PN **Physician** Whitaker January 6 2007 Anthony /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bactimore Hosp. tal If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1₩ 2□ F Yrs. Oct 5, 1962 Director 007-41-8507 Usual Residence of Decedent be filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at ty∑Yes 2□No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 21215 4717 Liberty Heights Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 12. Was Decedent Ever in U,S. Armed Forces? unk 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify: Specify: black δ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Lest) Be ္ဌ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2401 W. Belvedere Avenue Baltimore MD Sinai Hospital 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee Anthony D. Pleasant 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Mhono Baltimore, MD 21201 san 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician 10 Yut Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner Kaposi ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 2- No 1 ☐ Yes 2 ☐ No 1 🗆 Yes ne Hospital or Attending Physicien: Tr n 24 hours after death. ne Funerel Director: After this certificate pletely filled in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27 Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funerel Completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nim-0 Ka 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Si N. Gutan street - Dury

32. Registrar's Signature

State Registra

31. Date filed (Month, Day, Year)

**JAN 19** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrer 2. Date of Death 3 Time of Death Name (First, Middle, Last) Year **Physician** 12:53A <sup>™</sup> 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore County 3002 Lavender Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days **-12** M 2 1 X F 87 220 18 9841 Yrs. November 17 1919 Baltimore Co., MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Exactination routined at 1 Yes 2 No Baltimore County Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō LISA 21234 3002 Lavender Avenue Івтя 23в Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 21215-0036 1 ☐ Yes 2/X/No Specify: Specify: 3 Widowed 4 Divorced White "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic avent, the Medical 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic even" College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping-Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Sadie Laudenklos Harry C Babikow ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21234 3002 Lavender Avenue John H Wagner Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Murial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery January 20 2007 Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Sun iture of Funeral Service Liter see 7401 Belair Road Baltimore, maryland 21236 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 rea Priysician 2 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit The law requires that the death cartificate be exacuted the attending physician and Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical use as the If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown should be detached Division of Vital Records, P.O. ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an page 2 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of After Injury 5 Pending after death. 1 🗌 Yes 2 No investigation within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide building, etc. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Marylan		artment rtificate			nd Ment	al Hygien	Z U U /	01166
	Physicia	an	1 Decedent's Name (First, Middle, Las						iN	ate of Death Ionth D	ay Year	3. Time of Death
E.	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, 1	Town, or	Location of D			c. County of Dea	0
	Funeral		5. Social Security Number 6. Se		last birthday, Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min. (A	ate of Birth donth, Day, Yea	NNE HOL	thplace (State or Foreign untry)
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	v. Town or L	ocation			7(	-4-5	5 01	10d. Inside City Limits
	e Maryla 3a-f sho	ctor	MD ANNE AX		EVER	NA A	we K					1 ☐ Yes 2 ☑ No
	h with th	ai Dire	41 COACHMAN RD			10f. Zip		46			Citizen of What C	·
336	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show sical Examiner must be molified at	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Amed Forces? 1	S. 13.	Was Decedif Yes, spec		spanic Origin n, Mexican, F Specify:	n? (Specify \ Puerto Ricar	res or No- i, etc.)	14. Race - Am Black, Whi	te, etc.
215-0036	c 2 33	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	DO NOT us	k done d e retired)	uring most o	of working		Kind of Business	
d 2121	Hygi Hygi ther	0	17. Father's Name (First, Middle, Last)	•	ME	han	ic	18. Mother's	s Name (Firs	t, Middle, Maide	n Sumame)	Shop
Maryland	D 2 2 0	To B	KENT EDWARD U	Silliams	19b. Mail	ina Address	(Street a	Dodok	OF Rural Rou	PACE Ite Number, City	SEIGE or Town, State,	Zip Code)
_	s 1 and 2 shoul if Health and M Item 27 Is marl other traumati		TIMOTHY WILLIAMS, E	ROTHER	41 Ce	Achna	NRD			CK, MD. Z	1146	
Baltimore	8° = 5		20a. Method of Disposition  1  Burial 2  remation 3  4  Donation 5  Other (Specify	Romoval from State	Place of Disp cemetery, cre ATOWN	ematory or ot	ther place		-19-		Location - City of	
Balti	permit. Pag Department Important: eny injury o		21. Signature of Fureral Service Licen			2. Name and	d Ad Tes herty Fa	s of Facility amily Fune	ral Home A	and Cremation	Center, P.A.	
	*		23a. Part1. Enter the disease or compshock, or heart failure. List only	plications that paysed the deat	h. Do not er	nter the mode	2607.1 e of dying	yountain R	(0ad - Pat ardiac or res	sadena, MD.	MARY	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. MGTAS  Due to (or as a consequence)	uence of):	10 1	CA-	WCE	20	SIKUNI	UWW /	2
3/2	Examiner	Jer	Sequentially list conditions, if any, leading to immediate	b. LIVER Due to (or as a conseq	uence of):	460	IRC		, ,			44
)·	be executed sicien and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ACCOR	uence of):	_ H C	DO	111	ON			14
8760	icate be e physicier s the buri	cai	(	d								
O. Box 6	ne death certif the attending thed for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	death 3	□Ectopic pro					23d. Date of de Month	elivery Day Year
ds, P.O.	uires that the signed by the detaction	þ	Part II. Other significant conditions o	ontributing to death but not res	ulting in the	underlying ca	ause give	on in Part I.	West of the second seco	23e. Did tobacco		to the cause of death?
Records,	The law require sate has been sin page 2 should b	Completed								24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		of Death (Ch	eck only one)		
of	ding Phys h. After this funeral di	lon: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury		8c. Injury Work	4   Nurs	28d.	5 Mesidence Describe how in	6 ☐Other (Spejury occurred	ecify)
Division	Attender death	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ome, farm, s fy)				28f. L	ocation (Street City or Town, Sta		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical Co		ysician: To the best of my kno niner: On the basis of examina and manner stated.								
	To the Vithin To the Compl	Me	29b. Signature and title of confiler	, he t	40	290	License	number 3	9	29d. E	Date signed (Mon	nth, Day, Year)
	\		30. Name and address of person who	completed cause of death (tree	n 23a) (Type	e, Print)	Pa	RK.	inc	) 7	1776	
	Sta Regist		11. Date filed (North, Day, Year)	32. Registrar's Sign:	ature	Sell S		,,,	"(1		()	

		-	1 - For State of Maryland / Departm	ment of Health and Mo cate of Death	ental Hygie Reg.	ZUUI	01167	
	Physicia	153	1. Decedent's Name (First, Middle, Last)  DOLORES T WILLS		2. Date of Death	73 288ar	3. Time of Death 0708 м	
	/Medic Examin		2 000 100	. City, Town, or Location of Death	0.	4c. County of Death	1	
,	Funeral Director		216-01-0935 1 M 2 F 95 Yrs. Mo	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Ye 2/18/191	9. Birth Cou	nplace (State or Foreign Intry) YLAND	
	laryland show	or	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location           MD         BALTIMORE         ARBUTU				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	r 28a-f	irecto		Of. Zip Code	10g.	Citizen of What Co	untry?	
	th with	ralD	3308 BENSON AVENUE	21227		USA		
39	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menth Hygiene, the 27 is marked other than "natural", or itams 23s or 28s-1 show other traumatic event, If a Machine Exertiner must be notified.	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WH		
21215-0036	within 72 hou ene. than "nature	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind life. Do N	s Usual Occupation of work done during most of workin NOT use retired)	165		ind of Business/Industry	
	e filed within al Hygiene. other than '			KER 18. Mother's Name	(First, Middle, Mai	OWN HOME		
Maryland	2 should be and Mental is markad o	To Be	LEO VOGELSANG	MATILDA	ROSENDA	LE		
Man	id 2 shoul Ith and Me 27 is mari			ddress (Street and Number or Rural ADVIEW LANE ANN	Route Number, Cl		ip Code)	
	s 1 and of Healt item 2 othar		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or	Town, State	
imo	nit. Pages bartment of locatent: If it cortant: If it		'4 □Donation 5 □Other (Specify) METRO CREMA	TORY, INC. 1/22	:/2007 C	ATONSVILL	E,MD	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of once.		ile +t Ale /l.	me and Address of Facility THE			HOME, P.A. 1286	
	Physician /Medical		23a. Part. Enter the disease, or complications that cau. d the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a	e mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death	
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	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	n Ari			y can-	
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		_ Det	ighters	
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	To tha within 2 To tha complet	¥	COL Circulation and title of postifier	29c. License number  D 2/439	29d.	Jonuan	1. Day, Year) 4 /6, 2017	
	31		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	ExENSE HaHW	Ay A No	NAPOLIJ W	102401	
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 1 9 2007  32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #23e, perMD 6863, 1/23/07 IT Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Day **Physician** Shirley Wolf 3:15 p. /Medical January 17, 2007 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Ellicott City 4673 Morgan Court Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 SF Months Days Hours Min Director 220-38-1348 September 23, 1941 Washington DC Usual Residence of Decedent with the Maryland 10b Counts 10c. City. Town or Location 10a State 10d. Inside City Limits or 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 KNo Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 21043 4673 Morgan Court Pages 1 and 2 should be filed within 72 hours after deeth nent of Health and Mental Hygiene. and tems 23 int if Item 27 Ie marked other than "natural", or Items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Banking Elementary/Secondary (0-12) College (1-4or 5+) Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Clifford Oliver Proctor Emma Tyler Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other training once. 4673 Morgan Court Ellicott City, Maryland 21043 Mr. Adolph Wolf, Jr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/20/2007 Brentwood, Maryland Fort Lincoln Cemetery 22. Name and Address of Facility Slack Funeral Home, P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, you have a cardiac or respiratory arrest, which, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mon Small (Ell Lung Cancer Stage TU /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2XXNo Antmia Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death | Check only one examiner: 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) this After this funeral of 27. Manner of Death
1 Death
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tes 2 No investigation Director: / 6 □ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital

7

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Minford, Jon MD 31. Date filed (Month, Day, Year)

9

Medical

State Registrar

MA

32. Registrar's Signature

11055 Little Patuxent Pkwy. Columbia, MD 21044

iddress of person who completed cause of death (Item 23a) (Type, Print)

102 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

36573

29d. Date signed (Month, Day, Year)

1-18-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death ALBAUGH KATHARINE FLEAGLE Month **Physician** 2:45 P M January 11, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll County 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 220-03-3994 1 □ M 2 🕅 F 88 Yrs. Director July 9, 1918 Maryland Usual Residence of Decedent be filed within terms and the state of the s 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Carroll County Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2443 Mayberry Road 21158 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) restaurant manager restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any ligury or other traumatic event app. Edgar K. Fleagle Marie Stoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George T. Albaugh / son 2443 Mayberry Road Westminster, Maryland 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 20 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Tyrone, Maryland Baust Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** ACUTE KENAL /Medical Due to (or as a consequence of): Examiner SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit the death certificate be executed resulting in death) Last P.O. Box 68760 Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ■ No Month Day Year 5 Other (specify) signed by the at d be detached for 4 Pregnant at time of death 9 Unknown 9 Lloknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ CHRONIC LYMPHOCYTIC LEUKEMIA 1 Yes 2 No 3 Probably 4 ⊕ Onknown Completed peen CORONARY ARTERY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete hes t autopsy performed? 1 Yes 2 No 1 Yes 2 No After this certifice funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 1 Watural 5 ☐ Pending investigation death. 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 5 To the Hospitel o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M-D 01/11/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

FAKIHAR, M.D.

31. Date filed (Month, Day, Year)

477 E

BALT

32. Registrar's Signature

			For		State	of Ma							lental Hy		e e e e e e e e e e e e e e e e e e e	ibic.		
			1 - State Registrar					Ce	rtificat	e of L	Death			Reg. No	20	07	011	70
	Physici	an	1. Decedent's Name (First, Mid	ldle, Last)		-			3 .				2. Date of D	Da		Year	3. Time of	
	/Medic		William  4a. Facility Name (If not institut.	ion aive :		J.				toni	O Location o	of Death	Jan.	1		2007 y of Death	7:42	a <sup>M</sup>
	Examin	ier	25 Antonio Lan		arcor arro m	3111001)			Warw		Loodionio	, Doam			ecil			
	Funeral		5. Social Security Number	6. Sex		7. Age	(In yrs.	last birthday,		1 Year	If Under	24 Hrs. Min.	8. Date of Bi (Month, D			9. Birthp	lace (State of	r Foreign
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	and		Usual Residence of Decedent  10a. State 10b. Coun	ity			10c. Cit	y, Town or L	ocation							1	0d. Inside Cit	y Limits
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	r 28a	Director	10e. Street and Number	т			walv	VICK	10f. Zip	Code				10g. Cit	izen of	What Cour	itry?	
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	eme .	Funeral	11. Marital Status		12. Was Dec Armed F	cedent Ev	er in U.	S. 13.	Was Deced	ent of Hi	ispanic Orig	gin? (Spo	ecify Yes or N Rican, etc.)	0-		ce - Americ		
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Mar	12 c		19a. Informant's Name/Relation						_				A Route Numb			, State, Zip	Code)	
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ğ	Pages nent of int: If it iry or o	١,	1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from	State	C	emetery, cre	matory or o	ther place		an.	5,2007				,	
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o.	at the dea by the at tached fo	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Preg 9□Unkr	nant at ti	me of de	eath 5[	Other (sp	ecify)					IVIC	onth	Day Y	ear
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Division	or Attend after death Director: /	Certification:	4 ☐ Homicide dete	mined	286. Plac build	e of injury	y - At no (Specify	ome, farm, st y)	reet, factory	, office			28f. Location ( City or To			per or Hura	Houte Numb	00 <i>r</i> ,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one) 2 Madic	ei Examii	er: On the I	pasis of e	xamına	tion and/or in	vestigation	in my op	oinion, deat	th occurr	ed at the time,	, date and	place,	and due to	the cause(s)	
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	12	1	ame and address of person	on who co	mpleted cau	se of dea	ith (Item	23a) (Typ)	Print	<	75	1	, 20	2 I	M	/	11/2	1921
87	Sta	te	31. Date filed (Month, Day, Yea		32.	Registrar	s Signa	ture	1169	V (	1.0	41	- 000	<u> </u>	17	En /	W)	1104
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State of Maryland / Department of Health and	Mental Hygiene	0
Certificate of Death	Reg. No.	U
	La Barra d'Barris	-

		1	For State Registrar	State of Marylar	nd / Department of Health and N Certificate of Death	Mental Hygiene	07 01171
			Decedent's Name (First, Middle, I	ast)		2. Date of Death Month Day	3. Time of Death
	Physici /Medio		DAVID WHITE	AMENT		January 3;	2007 12:00 P M
	Examir		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Location of Death		nty of Death
		*	VA Maryland He	olth Care Sus	item Perry Point	Cei	
	Funeral Director		5. Social Security Number  215-18-1434  Usual Residence of Decedent	Sex 1 M 2 F 7. Age (In yrs. 85	Inst birthday) Yrs.  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 26, 192	9. Birthplace (State or Foreign Country)  1 MARYLAND
	and		10a. State 10b. County	10c. C	ity, Town or Location		10d. Inside City Limits
	d within 72 hours after death with the Maryland liene. r than "naturel", or teme 23a or 28a-f ehow the Myzikal Ezanta et must be motified at	ō	MARYLAND CECI		PERRY POINT		1 X Yes 2 ☐ No
	10 the	rec	10e. Street and Number	<u>-</u>	10f. Zip Code	10g. Citizen o	of What Country?
	h with	Funeral Director	VETERANS AFFAIR	S MEDICAL CENTE	R 21902	ı	U.S.A.
	deat	ner	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	Race - American Indian, Black, White, etc.
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121	within ene. than "	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	TOOL DESIGNER	ATRCRA	AFT MANUFACUTRE
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Maryland	be at a be	o Be	UNKNOWN AMENT		HARRIET	ELIZABETH WHIT	TE
Ī	s 1 and 2 should f Health and Mer Item 27 is marks other traumatic	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and Number or Ru		
	and 2 salth a n 27 is		FUNERAL HOME RE	CORDS	7606 OLD NATIONAL PIK	E, BOONSBORO,	MARYLAND 21713
Baltimore,	s 1 and of Heal		20a. Method of Disposition	20b.	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Locatio	on - City or Town, State
E O	Pages nent of ant: if it ary or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Conation 5 🖾 Other (Spe	Hemoval from State		8/2007 BOONSE	BORO MARYLAND
Ħ	그는 근 근 .		21. Signature of Faneral Service Lie	9 500	22. Name and Address of Facility	7606 Old Nati	
Ä	Depermine on yie		How MID		Dean BAST FUNERAL HOME	Boonsboro, Ma	aryland 21713
3	-		23a. Purt1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the dea	th. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a conse	quence of):		Oli II I Cook
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Records, P.O. Box 6	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregration of	nancy al death 3 Dectopic pregnancy death 5 Other (specify) sulting in the underlying cause given in Part I.	23e. Did tobacco use con the second s	Month Day Year  ontribute to the cause of death?  o 3 Probably 4 Unknown  b. Were autopsy findings available prior to completion of cause of
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State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	1 - For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of F rtificate of			iene	1	01176
	Physici		Decedent's Name (First, Middle, Last,     Thomas Allen A					2. Date of Death Month January	Day	0 <sup>Year</sup>	3. Time of Death 6:10 a M
	/Medio Examir		4a. Facility Name (If not institution, give 73 B Main Street	street and number)		4b. City, Town, o West	r Location of Dea minster	4c. County		)11	
	Funeral Director		210-30-3307	7. Age <b>\$</b> M 2□ F	9 (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		951	9. Birthp Cour West	olace (State or Foreign ntry) Virginia
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Carro	11		1	0d. Inside City Limits				
	with the 3a or 28a-	Funeral Director	10e. Street and Number 73 B Main Street			10f. Zip Code	2115	7	Og. Citizen of V	What Cour	itry?
336	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, if a Medical Exacting traumatic event, if a Medical Exacting traumatic event.	by Funera	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? ( an, Mexican, Pue Specify:	(Specify Yes or No- into Rican, etc.)		k, White,	can Indian, etc. white
21215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", or aurmatic event, II a Medical Eru	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	+) (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w d)	orking	16b. Kind of Bu Conve		
Maryland 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Edward Anderso	on		<del></del>		ame (First, Middle, M vie James	faiden Suman	18)	
	and 2 sho alth and h 27 Is ma er trauma		19a. Informant's Name/Relationship (Ty Debbie Frank, frie					Rural Route Number, Baltimore			Code)
Baltimore,	permit. Pages 1 and in Department of Health Important: If item 27 eny injury or other trence.		20a. Method of Disposition  1. Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cres Westminst	matory or other pla	0.4	<sup>Date</sup> '03/2007	20c. Location - Westmi		
Balt	permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service Licens	M0119				lyers—Durb Westmins			
	Physician /Medical Examiner		29a Part. Enter the disease, or complete stock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)	ne cause on each lin	the death. Do not enfine.  Lung a consequence of):	ter the mode of dyir		ac or respiratory arre	est,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	a consequence of):						
Box 6	death certifi e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnance Other (specify)	/		23d. Dai Mo	te of delive	ory Day Year
ds, P.O.	requires that the d een signed by the hould be detached	by	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the u	inderlying cause giv	ren in Part I.		acco use cont		ne cause of death?
al Recoi	The law ate has b page 2 si	Completed						24a. Was ar autops perform 1 \super Yes 2	ned?	Were auto prior to cor death? I  Yes	psy findings available mpletion of cause of 2 No
Vit		To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☐ Inpatie	nt 2 ER/Outpatier	nt 3 DOA Oth	000	eath (Check only one Home 5 KReside		er (Specify	y)
Division of Vital Records,	fing After fune	Certification; 7	27. Manner of Death  PS Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injur (Month, Day 28e. Place of Inju- building, etc	Year) Injury	M 1	yat k? Yes 2 ⊡No	28d. Describe ho  28f. Location (Str. City or Town	eet and Numb		d Route Number,
Ö	To the Hospital or Attenc within 24 hours after dealt To the Funeral Director: completely filled in by the	edical Cer	29a. Certifier (Check only 2 Medical Exemi	sicien: To the best oner: On the basis of	of my knowledge, deat	h occurred at the till vestigation, in my o	me, date and pla	ce, and due to the ca	use(s) and ma	inner as st	ated. the cause(s)
	To the within 2 Complet	Med	29b. Signature and title of certifier	and manner sta		29c. Licens	te number	j	od. Date signed	d (Month,	Day, Year)
-	25 J		30. Name and address of person who co	ompleted cause of di	eath (Item 23a) (Type,	Print)	Road	1 West	mins	Her	21157
	Sta	ite	31. Date filed (Month, Day, Year)	32. Flegistra	ar's Signature	hack .					

P.0. Division or Vital Records, To the Hospital or within 24 hours af To the Funeral D

> State Registrar

mani

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUMANA

D35295

10 St-Patricks Par. Svite 208, WALDORF, MD 20603

1/10/07

			For State Registrar	State of M	aryland		artmen <i>tificat</i>					jiene	07	01174
	Physici		Decedent's Name (First, Middle, La  Dorothy	<b>J.</b>		Вет	rnard				2. Date of Dea Month Janaury	ith	007 <sup>Year</sup>	3. Time of Death 8:20 P M
	/Medio		4a. Facility Name (If not institution, giv							of Death		1	unty of Death	
***	Funeral Director		.02 20 100 1	Sex 7. Ag I□M 2 <b>X</b> F	ge (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	if Under Hours	24 Hrs. Min.	8. Date of Birth Feb. 23	, <sup>7</sup> 1926	9. Birth <b>Ken</b>	place (State or Foreign Lucky
	rland ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	e Man	ctor	Maryland Frederi	ck	Fred	erick								1 X Yes 2 No
	th with th	Funeral Director	1798 Valleyside D	rive			10f. Zip	217	02				of What Cou USA	untry?
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural; or Itema 23a or 28e-f ehow other traumatic event, Ita Mudical Exacting Institutal Legicillied at	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 █ Divorced	12. Was Decedent Armed Forces  1 Yes 2  If Yes, Give Year or Dates:	?	1	Was Deced f Yes, spec 1 ☐ Yes	city Cuba	n, Mexicar	n, Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White ecify:	
2-0(	72 hou	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	lent's Usua kind of wo	al Occupa	ation during mos	t of workin	na	16b. Kind o	of Business/li	ndustry
21215-0036	12 should be filed within h and Mental Hygiene. 7 le marked other than "! traumatic event, Ire Mis.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	00 NOT us C <b>1e</b> :	se retired	)			Trans	portat	ion/Commun.
	al Hygi I other	Be C	17. Father's Name (First, Middle, Last	)					18. Mothe	er's Name	(First, Middle,		<u> </u>	
Maryland	d Ment d Ment narked natice	ပ္	Joseph		Peaco			/2		_	M. Gi			
Ma	and 2 st salth and n 27 le r		19a. Informant's Name/Relationship ( Mary Lou Bernard/		-		-				Route Numbe Frederi			
ore,	8 5 5 6		20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 ☐		20b. Pla	ce of Dispo	sition (Nan	ne of ther place	-1	Di	ate	20c. Locati	on - City or T	own, State
Baltimore,			4 □ Donation 5 □ Other (Special		Sta	uffer			1		-Joo <del>)</del> auffer			
Bal	permit. Pa Departmer Important eny injury once.		21. Signature of Juneral/Service Tick				. Name an			,	ke, Fre			
Physician /Medical Examiner  Sequentially list conditions, if any, leading to immediate cause. Therefore the disease or complications that caused the death. Do shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to for as a consequence of the cause. Enter Underlying Cause (Disease or injury)							-	le of dying		/	Pouce			Approximate Interval Between Onset and Poath
8760,	cate be executed physicien and the burial-transit	dical Examiner	that initiated events resulting in death) Last	c.  Due to (or as a consequence of):  d.										
P.O. Box 6	The law requires that the death certificate be executed ate bas been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 points? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pr Other (sp					23d.	Date of deliving	very Day Year
Records, P	w requires that been signed t should be det	by	Part II. Other significant conditions of	contributing to death t	out not result	ing in the ur	nderlying c	ause give	en in Part I.	•		bacco use d es 2□N		the cause of death? bably 4 Unknown
al Reco		Completed									24a. Was a autops perfor 1 Yes	SV	4b. Were aut prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes  No	Hospital: 1 ☐ Inpati		R/Outpatien		Othe			(Check only of		Du 10	/
Division of	ding Pi	atlon: To	27. Manner of Death 1 Natural 5 Pending Accident investigatio	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work	4 (4+10	2	ne 5 Residi 8d. Describe h			ry)
Divis	To the Hospitel or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not b	building, e	tc. (Specify)						City or Tow	n, State)		al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in In	Medical	29a. Certifier (Check only one)  Certifying Place   nysician: To the best miner: On the basis of and manner st	of examinatio	ledge, death on and/or in	occurred occurred occurred on,	at the tim in my op	ie, date an pinion, de <i>a</i>	d place, a th occurre	nd due to the c d at the time, d	ause(s) and late and pla	d manner as a ce, and due	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and little of certifier	11	1		29	License	number		2	9d. Date sig	gned (Month,	Day, Year)
			Kreft.	( and	ma	~		レー	1397	7		1/	4/0	7.
_	10		30. Name and address of person who Dr. Robert Kauf	manh 3	00 W.	Ninth	Print) Stre	et	Free	deric	k,MD			-
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 0 5 20	107 Chegist	rar's Signatu	for Son	who							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 2, 2007 **Physician** 4:02 PM June Isabelle Beachy /Medical 4e Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Grantsville Garrett Goodwill Mennonite Home | Months | Days | Hours | Min. | Sept. | 16,1918 | Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 1 F 214-34-1343 Yrs. 88 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after daath with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural; or items 23e or 28e-f show ary or other traumatic event, the Medical Examinar must be nottled at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 X No Grantsville Garrett 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 506 Rocky Acres Rd. 21536 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2X No Specify: 2 Specify: 3
☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) MD DNR Elementary/Secondary (0-12) College (1-4or 5+) Park Service 12 Maintenance 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Stephen Elizabeth Victoria Opel 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Rocky Acres Rd., Grantsville, MD Thelma J. Bever/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery Jan. 5, 2007 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Newman Funeral Homes, P.A. unae P.O. Box 275, Grantsville, 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or as a con Examiner physician and s the burial-transit mond The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): esn ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has certificata has irector, paga 2 2 X No 1 ☐ Yes 2 ☐ No TO Yes Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 After this 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel within 24 hours aftar death.

To the Funeral Director: All complataly filled in by the fu 1 Yes 2 🗆 No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0020

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Dr. Robin Bissell, M.D., 124 Miller St., Grantsville, MD

31. Date filed (Month, Day, Year) State

32. Registrer's Signeture

2007



200

Registrar

State of Maryland / Department of Health and Mental Hygiene

			,	Certificate of Death	Re	Z U U /	01176
			1. Decedent's Name (First, Middle, Lest)		2. Date of Deeth Month		3. Time of Death
	Physicia /Medic		Robert Earl Burt		January	4, 2007	11:15 AM
	Examine		4a Fecility Neme (If not institution, give street end number)	4b. City, Town	n, or Location of Deeth	4c. County of Dea	
			Dennett Road Manor Nursing Home	0aklan		Garrett	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest b	Months Days Hours	Hrs. 8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
	Director		573-20-1420 80	Yrs.	Aug. 26,	1926 Ca	lifornia
	and		Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, To	wn or Location			10d. Inside City Limits
	Mary	ō	MD Garrett Oak	land			1 XYes 2 □ No
	the north	rec	10e. Street end Number	10f. Zip Code	10	g. Citizen of What C	ountry?
	3a or	Funeral Director	1113 Mary Drive	21550		United St	•
	deeth	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispenic Origin If Yes, specify Cuban, Mexican, F		14. Race - Am	erican Indian,
ထ	or ite	בֿ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No		Puerto Rican, etc.)	Black, Whi	ite, etc.
8	ours a	þ	3 X Widowed 4 □ Divorced If Yes, Give Yeer or Dates: WWII Korea	1 ☐ Yes 2 ☐ No Specify:		Specify: W	hite
5-0	72 ho	e e		e. Decedent's Usual Occupetion (Give kind of work done during most o	of working	6b. Kind of Business	s/Industry
21	be filed within 72 hours aftar deeth with the Maryland stal Hyglena. d other than "natural", or frems 23a or 28a-f show event, the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most o life. DO NOT use retired)			
2	filed within Hyglena. Ither than than than than than than than than	ပိ	12 17. Father's Name (First, Middle, Last)	Mailroad Conductor		Railroad	
anc	ntal h	Be			s Name (First, Middle, M		
Ž	should be filed and Mental Hygl s marked other numatic event,	ှ	Joseph Burt  19a. Informant's Name/Relationship (Type, Print)  19	Oliv		Wishman	7:- 0 - 4-1
Ma	d 2 sho th end 7 is me traume			b. Mailing Address (Street and Number			ZIP COde)
e)	s 1 and 2 should f Haaith end Men tem 27 is marke other traumatic	ł	20a Method of Disposition 20b. Place	21 N. Second St., Conf Disposition (Name of		0c. Location - City or	Town State
5	ages int of it. if it		1 ☐ Buriel 2 X Cremation 3 ☐ Removal from State	ery, cremetory or other place)			
Baltimore, Maryland 21215-0036	permit. Pages 1 an Dapartment of Haal Important: if Item 2 any Injury or other once.		4 Donation 5 Other (Specify) Cumb e	rland Crematory  22. Name and Address of Facility	1/5/07	Cumberlan	d, MD
B	Day Imp				Second St.		
			23a Pert 1 Enter the disease or complications that caused the death. Do			-	Approximate
	Physician		23a. Pert1. Enter the disease, or complications that obused the death. Do shock, or heart failure. List only one cause on each line.	The content are mode of dying, door as ou	duo on roopingtory union	24,	Interval Between Onset and Death
	/Medical		Immediate Ceuse (Final				1 day
	Examiner		disease or condition resulting in death)  Due to (or exa	consequence of):			1 2 4
	n #	Der		bronchitis			Wears
	requires that the death certificate be executed seen signed by the attending physicien end hould be detached for use as the burial-trensit	Medicai Examiner		consequence of):			
8	Sien e	<u> </u>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury				1
68760,	sate b	<u>8</u>		consequence of):			
<b>×</b>	ding (	Me	d				
Bô	eath ce attandi I for use	Physician					1
P.O.	t the de by the s	Š	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.			e to the cause of death?
	es that the signed by be detact	2	dia petes mellitus type	· two	12 Yes	8 2□ No 3□ P	Probably 4 Unknown
Vital Records,	uires n sigr	g D		1 1.	24a. Was en		Were autopsy findings
2	w require	ete	atheroscleretic cordiovi	isculor disease	perform	ed?	available prior to completion of cause of deeth?
æ	The law	Completed	chronic renal failure	Stage three	1 □ Yes	2 <b>16</b> No	1 ☐ Yes 2 ☐ No
<u>ta</u>	Iclan: The	D D	25. Was case referred to medical	J , , C O	Death (Check only one	•	10163 20160
2		οl	examiner? 1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/O	Other	ing Home 5 ☐ Residen		ecify)
0	g Physical distribution	<u> </u>		Time of linjury at Work?	28d. Describe hov		
<u>ō</u>	ath. Sr: Af he fu	ğ	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of	re Attender de l'recte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Stre City or Town,	et and Number or R State)	urel Route Number,
	rate of rate o	3					
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edicai	29a. Certifier   Table 1   Certifying Physician: To the best of my knowledg (Check only one)   Medical Examiner: On the best of examination ended and memory stated	<ul> <li>a, death occurred at the time, date end p</li> <li>nd/or investigation, in my opinion, death</li> </ul>	place, and due to the ceu occurred at the time, dat	ise(s) end manner e e and place, and du	s stated. e to the cause(s)
	o the o the omple	ž	one) end menner steted.  29b. Signature end title of certifier	29c. License number	296	d. Date signed (Mon	th, Dey, Year)
			Alle Man MI	1 10025	754 -	Tanuary	42007
1	IVA	-	30. Name end eddress of person who completed cause of deeth (Item 23e)	(Type, Print)	,	January	117
			Welter K. Neumann +	1D PO 30x 24	7. Acrident	- MD21.	520
	State	е	31. Dete filed (Month, Day, Year) 32. Registrer's Signature	A. a. Al a			
	Registra	r	JAN 4 ZUU/ Detter De	Contract of the second			

			For State Registrer	State of	Maryland		artment of I			al Hygie Reg.	ZUUI	0117	7
	Physici	an.	1. Decedent's Name (First, Middle, Li		101111				Mo	te of Death	Day Year	3. Time of Death	_
	/Medic	al	Rosemary There					1 0		nuary	4, 2007	16:20 M	A —-
	Examin	er	4a. Facility Name (If not institution, gi		D <del>0</del> T)		4b. City, Town,				4c. County of Death		
	Funeral		11707 Pheasant T 5. Social Security Number 6.		'. Age (In yrs. la	st birthday)	If Under 1 Year		24 Hrs. 8. Dat	te of Birth	Washingt 9. Birth	place (State or Foreig	n
	Director		379-28-6557	1 □ M 2 <b>X</b> F	76	Yrs.	Months Days	Hours		onth, Day, Ye		intry)	
and	<b>≱</b> 12		Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Lo	eation					10d. Inside City Limits	c
Maryk	d e ho	٥			1.00.0.0,							1 ☐ Yes 2 📉 No	
the	28a-	Director	Maryland Washir  10e. Street and Number	gton		над	erstown 10f. Zip Code			10g.	Citizen of What Cou	intry?	
th With	23a o		11707 Pheasant T	rail				21742			USA		
r dee	E US	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S	3. 13.	Was Decedent of I		igin? (Sp <i>eci</i> fy Ye	es or No-	14. Race - Ameri Black, White		_
<b>-UU36</b> hours after deeth with the Maryland	jiene. r then "naturel", or Items 23a or 28a-f ehow the Mudical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes ti Yes, Give	1960-6	63	1 ☐ Yes 2 🌠 No			,	Canaihe		
15-0036 72 hours af	iture E	ed b	15. Decedent's 8		105:		dent's Usual Occu	nation		16	. Kind of Business/Ir	hite	_
- <b>CT2T</b> : within 72	Nedlo	Completed	(Specify only highest gi	rade completed)	405 5 1)	(Give	kind of work done DO NOT use retire	during mos	st of working	100	7. Kind of Business/ii	laustry	
Z Will	giene er the	E O	12	College (1-	401 3+)		Nurse	2			Hospital		
be filed	d other event,	Be (	17. Father's Name (First, Middle, Las	t)				18. Moth	er's Name (First,	Middle, Mai			
<u>s</u>	Men	၉	Walter Baumgart						nes Bie				
Mar d2 sh	h and 7 is my traum		19a. Informant's Name/Relationship								ity or Town, State, Zi		
	f Health Item 27 other tra		Ralph Cunningham 20a. Method of Disposition	- Husba		II/O	/ Pheasar sition (Name of matory or other pla	nt Tra	ail, Hago Date		m. Md. 21 Location - City or T		_
Pege.	0 = =		1 ☐ Burial 2 X Cremation 3 if		late			!	1 /5 /07				
Baltimore, Dermit. Peges 1 ar	Department Important: I any injury o		21. Signature of Funerat Service Lice		нае		on Cremat				gerstown. FUNERAL H		-
n a	Par in g		Fred LU	ester			415 E. W	ilson			stown, Md.		
Die			23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final	nplications that ca	used the death.							Approximate toterval Between Onset and Death	
	ysician Medical		disease or condition resulting in death)	a. Due to (c	Wasa consequ	ence of):	an ru	11416				12 AU2	
Ex	xaminer		Cognestially list appditions	Athe	rascle	notic	- Condi	Vasi	ular.	Dispu	se	25 Y/S	
g		Iner											
Gecute	and I-trans	Examiner	that infliated events c										
8/6U, ate be executed	ohysicien and the burial-transit	dical E		o .	20 0 00110040	01100 017.							
<b>68/</b> ifficate	phys as the	edlc		d									
Hecords, P.O. Box 6: The law requires that the death certific	ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outc	ome of pregnan		Tm				23d. Date of deliv	rery	
deat G	ne ett	sicia	in the past 12 months?		nt at time of de		Ectopic pregnanc Other (specify)	у			Month	Day Year	
J i	by the estached	Phys	9 Unknown										
ies i	signed I	þ	Part II. Other significant conditions	contributing to dea	ath but not resul	Iting in the u	nderlying cause gr	ven in Part I	1. 23	_	co use contribute to		
0.00	been si	eted	- UIMDETES	> 1110	W Lus	· 14				1 Tes	No 3□Pro	bably 4 □Unknowr	1
Vital Records, sician: The law requires t	has Je 2	Completed	****						24	<ul> <li>a. Was an autopsy performed</li> </ul>	prior to co	opsy findings available empletion of cause of	Θ
	certificete rector, pag	မ ငိ	25. Was case referred to medical	T						Yes 2		2 No	
		To B	examiner?	Hospital: 1 🗆 In	patient 2 2	B/Outpatier	nt 3□ DOA Dt	200	e of Death (Checursing Home 5)		e 6 ☐Other (Speci	.6.1	
ָ סר קַּ	h. After this funeral di		27. Magner of Death	28a. Date of		28b. Time o					ntury occurred	'Y)	
old indi	death. ctor: Af y the fur	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	on	, bay roan	milary		Yes 2	No				
DIVISION OF	E .	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place	of Injury - At hor g, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Loc City	cation (Stree y or Town, S	t and Number or Rur tate)	al Route Number,	
pital o	hours a uneral D		29a. Certifier 1 Certifying P										
Hos	24 hc	edical	(Check only 2 Medical Exa	miner: On the ba	sis of examinati	on and/or in	vestigation, in my	me, date ar opinion, dea	nd place, and due ath occurred at th	e to the caus ne time, date	e(s) and manner as and place, and due to	stated. to the cause(s)	
DIV To the Hospital or	within 24 hours after To the Funeral Dir completely filled in	Me	29b. Signature and title of certifier	Л	1		29c. Licen	se number		29d.	Date signed (Month,	Day, Year)	
			1 /Timas	(	1/00,00	nan	Coxac	175	91	1	an 5	2/107	
			30. Name and address of person who	completed cause	of death (Item	23а) (Туре,	Print)		* t	, ,	viii p	~~ ·	_
SH	-10+1		illio Medical	Compus	KO, 2	HC 13	d, Mag	ersto	Wn, M	di	21742		
	Sta Registi		31. Date filed (Month, Day, Year)	2007 32. Re	gistrar's Signati	M. I	halle o						

				State of Maryland				•	_	01170		
		•	1 - State Registrar		-	tificate of			g. No.	011/8		
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death		
	/Medic	al	Edward CORBETT Jr  4a. Facility Name (If not institution, give st			4h City Town o	r Location of Death	Druny	4 200 de. County of Dear			
	Examin	er	Washington County				erstown			ngton		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days						
Ц	Director		220-10-4303	M 2□F   80	Yrs.	Widillia Days	Tiours Will.	8. Date of Birth (Month, Day, Dec. 26	, 1926 Ma	ryland		
	ow and		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits		
:	a-feh	tor	Maryland Washing	gton	Н	agerstown	ı			1 ☐ Yes 2¾☐ No		
	or 28	)ire	10e. Street and Number			10f. Zip Code			Citizen of What Country?			
bosive Marth the Marcland	23a	Funeral Director	13628 Pennsylvania		101		L742		USA	- Andrew		
	r them	Fune	11. Marital Status 1  1X Never Married 2 Married 1  1X Never Married 2 Married 1	<ol> <li>Was Decedent Ever in U.S. Armed Forces?</li> <li>1 ☐ Yes 2 ☒ No</li> </ol>	vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	реслу Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	e, etc.			
200	be flied within 72 hours effer death with the Marylar lat Hygiene. Ital Hygiene. d other then "naturel", or theme 23a or 28a-f ehow event, the Mudical Examinar must be multified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	I□Yes 2⊠XNo	Specify:		Specify: W	hite			
<u>ה</u>	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	lent's Usual Occup	ation during most of world)	king	16b. Kind of Business	/Industry		
7	within 72 ene. then "nat he Medic	dmo	Elementary/Secondary (0-12) unknown	College (1-4or 5+) Inknown		driver	3)		transport	ation		
ם פ	il Hygiene other the vent, the	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M				
_	5 <b>2</b> 9 4	ToE	Edward Corbett				Nellie	unkno	.own			
Mar	d 2 shou th and M ?7 is mar treumati		19a. Informant's Name/Relationship (Type Kathleen Free - fr	1		-			City or Town, State,			
e)	Heal Heal ther		20a. Method of Disposition			sition (Name of natory or other place			20c. Location - City or			
Бактто	permit. Pages Department of Important: If It any Injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			natory or other plac yn Cremat				n, Maryland		
	permit. I Departm Importar any Injui		21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUN									
<u> </u>	Deg man		Cott /	Mumil					stown, Md	. 21740		
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.	Do not ent	D		Δ		Approximate Interval Between Onset and Death		
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	YULSELBS	3 8	LBC721	CAL	HETIU	174			
	Examiner		f .	Due to (or as a conseque	2 A-12	PNEU	HONIA	WIT	#			
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque		. 1000	7 (0 10 (7)		1			
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque		>A CIU	111	SPUT	UM			
	m 9 m	caiE	L.	CHRONIC		BSTRI	DETIVA	PULH	ONARY			
	leath certificate attending phy f tor use as the		J				DISTAR					
X Q	death certifical e attending phy d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnand 1 Live birth 2 Fetal of	Ectopic pregnancy		livery Day Year					
5	at the dea by the a lached t	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown	ath 5□	Other (specify) _			Month	Day 70a.		
ı.	signed by d be deta	y Ph	Part II. Other significant conditions cont	tributing to death but not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
Hecords,	law requires that as been signed b 2 should be deta	Completed by	ATRIAC GIBR	1LCA710N				1 □ Ye	s 2□No 3□P	robably 4 🗆 Unknown		
၁	nasbe nasbe	pie	TOBACCO A	BUSE				24a. Was ar	v prior to	utopsy findings available completion of cause of		
	ilcien: The lav certiticate has rector, page 2		PROFOUND F	1ALNUTRI-	710A	)		perform 1 Tes 2	ned? death?	2 □ No		
VItal	sicien: certific lirector,	o Be	25. Was case referred to medical examiner?	ospital: 1 npatient 2 = E	R/Outpatier	Oth		th (Check only one				
0	g Physier this seral di	n: To	27. Many r of Death		28b. Time of			28d. Describe ho	nce 6 Other (Spe w injury occurred	icity)		
Sior	uttending I death. ctor: After y the tuner	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Bay 16a)	Injury		Yes 2 □No					
DIVISION	I or Attend atter death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,		
-	To the Hospital or Attending Physicien: within L2 thours state death.  To the Funerel Director: After this certific completely tilled in by the tuneral director,		29a. Certifier 1 Certifying Phys	ician: To the best of my know	ledge, deatl	n occurred at the tir	ne, date and place	, and due to the ca	use(s) and manner a	s stated.		
	the Ho in 24 I the Fu ipletely	Medicai	one)	er: On the basis of examination and manner stated.	on and/or in	vestigation, in my d	pinion, death occu	rred at the time, da	ate and place, and due	e to the cause(s)		
	vithin 2 To the comple	Σ	29b. Signature and title of certifier	1 Lacon	1110	29c. Licens	e number	29	9d. Date signed (Mont	th, Day, Year)		
			20 Name and address of the	revolution TUSTI	4L >	Doo	6359	6	11410-	T		
5+	1-1		30. Name and address of person who con		23a) (Type,	ANTILE	7AH	STREAT	HAG, H	D		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		<i>*</i>			<del>)</del> '/			
	Registr	ar	JAN 0 5 20	11/	M B	00.1.1						

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner be executed burlal-trar Box 68760, physician the as

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certificate

this

P.O.

Division or Vital Records,

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show must be notifled

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or items 23a

"natural"

Pages 1 and 2 should be filed within Trent of Health and Mental Hygiene. ant: If Item 27 is marked other than '

Department of Health a Important: If Item 27 is any injury or other tra

traumatic event, the Medical Examiner

72 hours after death

filed within

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

Examiner Physician/Medical use atten for u signed by the þ been signated by the second of Completed cate has t page 2 s director Be P After th funeral Certification: the Funeral Director: After the fulled in by the fu

Medical

the 0

Hospital or Attending

State Registrar Khi Nack, MD

NAIK

6 Could not be determined

3 Suicide

RAKHI

29a. Certifier (Check only one)

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number RES - 000

29d. Date signed (Month, Day, Year) JANUARY 1 2007

MD

21205

Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

600 NORTH gistrar's Signature

WOLFE STREET

/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. $^{\sim}$ After death. Director: / within 24 hours after dea To the Funeral Directo completely filled in by th

**Physician** 

Examiner

**Funeral** 

Director

or 28s-f show

event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or items 23a and injury or other traumatic event, the Madipal Ferrotters and Industrial Process.

Physician

Examine

Physician/Medical

δ

Completed

Certification; To Be

Medical

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non insulin dependent diabetes mellitus Parkinson's disease 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 2 ☐ Accident 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number
D 00 6/6/14 29d. Date signed (Month, Day, Year) K. Dindhum January 11/2007

RAVINDER SINDHWAN

State Registrar

31. Date liled (Month, Day, Year)

11350



PEMBRUOKE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



SQUARE

			For State	State of Marylar	nd / Department of		lental Hygier	ne 0 7	01181
			Registrar		Certificate o	t Death	Reg.	No.	
н	Physici	an	1. Decedent's Name (First, Middle, Last)	D.C. LALA	IVIS		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Elicabeth +	1101			JAN. O	1 2007	1035 M
1	Examin	er	4a. Facility Name (If not institution, give	treet and number)	4b. City, Town	, or Location of Death		4c. County of Death	
			Kninsula Legional	medical Cen	last birthday) If Under 1 Yes	ar If Under 24 Hrs.		Wicomi	10
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	Yrs. Months Day		8. Date of Birth (Month, Day, Ye	ar). Cour	place (State or Foreign
	Director		Usual Residence of Decedent	7 3	Ø 113.		1-21-	30 ma	iryland
	and		10a. State 10b. County	10c. Ci	ty, Town or Location			1	Od. Inside City Limits
	Many	ō	Md WICON	nico So	alisbury				1 Yes 2 No
	the 28s	Director	10e. Street and Number	1100	10f. Zip Code		100	Citizen ol What Cour	nto/2
	with a or		2179 Right	arough de	ا ک	221	1.09.	$II \subseteq \Delta$	my:
	hours after deeth with the Maryland turel', or items 23a or 28s-1 show al Exant ar must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U	IS 13 Was Decedent of	Hispanic Origin? (Sp	acity Vas or No-	14. Race - Americ	ean Indian
	ter d	ä	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 1 No	If Yes, specify Co	l Hispanic Origin? (Sp uban, Mexican, Puerto	Rican, etc.)	Black, White,	
38	irs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 👀	lo Specify:	<b>→</b> →	Specify: B	ACK
21215-0036	72 hours "naturel",		15. Decedent's Edu	cation	16a. Decedent's Usual Occ	cupation	16b	. Kind of Business/In	dustry
715	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of work dor life. DO NOT use reti	ne during most of work ired)	ing	Aluseria	
27	d within jiene. r then	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)	Private du	tr care	taker 1	VULSIN	19
	be filed within 72 ho ital Hygiene. Id other then "natur event, the Medical	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Maid	len Sumame)	
Maryland		ToB	Glover I	av) s		MARI	HAI	R STON	
ary	shoul and Me le mari	-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailing Address (Stre	et and Number or Run	al Route Number, Cit	ty or Town, State, Zip	Code)
Σ	s 1 end 2 should f Health and Mer item 27 le marke other treumatic		Mary Davis (1	nother	8/79 Brin	+ branch	dr. Sali	show m	d 21801
ē,	f Heil item othe		20a. Method of Disposition	20b.	Place of Disposition (Name of cemetery, crematory or other p			Location - City or To	V
Ę	Pages ment of ant: If it ury or o		1 ■ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State   🥕	reen acroc Mi	01	8-07 5	Michigan	md
Baltimore			21. Signature II Funeral Service License	90 ,4	22. Name and Add			Isabell	651
ä	Departition Department Imports any of source.		THELTU		BANNIS	mill F/H		buny ma	
			23a. Part1. Enter the disease for complishock, or heart failure. List only or	cations that caused the dea	th. Do not enter the mode of d	lying, such as cardiac		3.77	Approximate
4	Dhusisian		shock, or heart failure. Cist only or Immediate Cause (Final	1	1 /	1 01			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	wac ary	ly Du	•		25 mil
	Examiner			Due to (or as a consecutive of the consecutive of t	Car - 2 m	1000	2-4		1
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):	aginalo	e) a my		1000
	d ansit	Ε	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ć	exec n en ial-tr	Examiner	resulting in death) Last	Due to (or as a consec	quence ol):				
8760	The law requires thet the death certificate be executed the has been signed by the ettending physicien end hage 2 should be detached for use as the burtal-transit	dlcal							
9	ifficat g phy as th	ed	,		112				
Вох	eath certific ettending p I for use as	Z	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn				23d. Date of delive	ay N/A
œ	death e ette d for	cla	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		ncy		Month	Day Year
0	by the de	Physician/Me	9 Unknown	9□ Unknown					
0	igned be det	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying cause	given in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?
Vital Records,	quire n sig uid b		- ( Prome	Kent Fac	lece		1 ☐ Yes	2 No 3 Prob	ably 4 Onknown
ပ္ပ	aw requir as been si 2 should	ompleted	- Dishet	Manho	1.4		24a. Was an	24b. Were auto	nsv findings available
Re	The lay	E		- Degrad	2009		autopsy performed	?death?	psy findings available mpletion of cause of
ta		ပိ	25. Was case referred to medical			OC Diseased Deski	1 Yes 2	No 1 □ Yes	20 NG
		0	examiner?	ospital: 1 Impatient 2	ER/Outpatient 3 DOA	Other	Check only one		
ō		Ë	27. Mann Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. In		28d. Describe how in	6 □Other (Specify	<i>(</i> )
lon	th. : After s funer	皇	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		/ork? ☐ Yes 2 ☐ No			
Division of	of attending effer death. I Director: After din by the fune	Ę	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, larm, street, lactory, officity)	e		and Number or Rura	I Route Number,
Ö	el or s efte i Diri	Certification;	4   Homicide	building, etc. (Speci	fy)		City or Town, St	ate)	
	a Hospitel		29a. Certifier 1 Carrilying Phys	rcian: To the best of my kn	owledge, death occurred at the	time, date and place,	and due to the dause	(s) and manner as s'	ated.
	To the Hospitel or Attenwithin 24 hours effer deat To the Funeral Director:	Medical	(Check only 2 Medical Examinations)	er: On the basis of examination and manner stated.	ation and/or investigation, in my	y opinion, death occurr	ed at the time, date a	and place, and due to	the cause(s)
	To the h within 24 To the F complete	Σ	29b. Signature and title of certifier	1 /	29c. Lice	nse number	29d. I	Date signed (Month,	Day, Year)
	1717		De Sen S	S./2	anno 1	1-2003	S)	1/1/04	
-			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Print)	0		117	1,
				CHAW 1	340 South	Divison S	7. Suls	30%, Solu	4 , HOSBER
	Sta		31. Date liled (Month, Day, Year)	32. Registrar's Sign	ature				- Sur
	Registr	ar	JAN 03 20	107	He Rosalle				/

		1 - For State Registrar	State of N	/larylar				lealth a D <i>eath</i>	ınd M		giene Reg. No.	00	7	01182
Physic		1. Decedent's Name (First, Middle, Las Julie Ann Dana								2. Date of Dea Month Januar	Day		Year	3. Time of Death  11:35 A <sup>M</sup>
/Medi Exami		4a. Facility Name (If not institution, give 232 Wintergreen		or)		4b. City,		Location o		oundar		County	of Death deri	
Funeral Director		5. Social Security Number 6. S 249-29-6872 Usual Residence of Decedent	9x 7. / □M 2 1 F	Age (In yrs. 48	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da May 31	h y, Year) , 19!	58	9. Birthp Cour SCC	elace (State or Foreign etland
ne Marylend 8a-f show	Director	10a. State 10b. County  Maryland Frede	rick	10c. Ci	ty, Town or Lo	ick					10d. Inside City Limits 1 √2 Yes 2 □ No 10g. Citizen of What Country?			
th with ti	al Dire	10e. Street and Number  232 Wintergr	een Lane			10f. Zip		21716					hat Cour Stat	•
Nore, Maryland 21215-0036 ges 1 end 2 should be filed within 72 hours after death with the Maryland at of Heatth and Mental Hygiene. If itam 27 is marked other than "natural, or items 23s or 28s-f show or other treumatic event, the Marked Expiriting must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2版 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? XiNo				ispanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)			k, White,	an Indian, etc. aite
21215-0036 d within 72 hours aff giene. or then "natural", or the Modical Expire	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4o	or 5+)	life.	kind of wo DO NOT u	erk done d se retired	during most		ng			siness/Ind	,
Maryland 2121 (d. should be filed within 1 and Mental Hygiene. To le merked other then "treumstic event, the Mer.	To Be C	17. Father's Name (First, Middle, Last)  Clifford Bib	le						Rit	a Kaul	ig			
, Mar end 2 st satth and n 27 le m er treum		19a. Informant's Name/Relationship ( Alan Danaher / Hu								A Route Numbe Brunswi				
Baltimore, Misperial Pages 1 end 2 Department of Health a Important: If Itam 27 I any njury or other tre once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		te	Place of Dispo cemetery, crei auffer	natory or o	other plac			2007				own, State Maryland
Balti permit. Deportri Importa any ruju		21. Signature of Funeral Service Licen	Staus	llas	22					auffer ave.,				D 21716
Physician /Medical		23a. art1. Enter the levase or com shock, or heart fail in a List only Immediate Cause (Final disease or condition resulting in death)	one cause on ach	i line.	3/	-					rrest,			Approximate Interval Between Onset and Death
cate be executed by sician and the buriat-transit	dical Examiner	Sequentially list conditions. It any, loading to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or a Due to (or a	as a consec	uence of):	b-	<u> </u>	7//	m	1/0	n			8 mo
Box 6 death certifi a ettending a	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♠No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of c	aldeath 3	Ectopic p		,			2	3d. Date Mor	e of delive	ery Day Year
cords, P.O w requires that the been signed by th should be detache		Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlying o	ause giv	en in Part I.			obacco u: /es 2[		ibute to th	ne cause of death?
Rec he law e has b	Completed									24a. Was autop perfo 1 🗆 Yes		p	rior to co leath?	psy findings available mpletion of cause of 2 No
of Vital Physician: 1 rithis certificet ral director, pi	To Be	25. Was case referred to medical examiner?  1 Yes 2 Yes	Hospital:	ationt 2	] ER/Outpatier	nt 3□ D0	Oth	00		me 5 Resid			· (C	
C 5 5 5		27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, I		28b, Time o Injury		28c. Injur Wor			28d. Describe h				y)
Division To the Hospitel or Attending within 24 hours effer death. To the Funaral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	286. Place of	Injury · At h etc. (Speci	iome, farm, sti fy)	eet, factor	y, office			28f. Location (5 City or Tox	Street and wn, State)	d Numbe	er or Rura	il Route Number,
he Hospi n 24 hour ne Funar sletely fill	edical	29a. Certifier (Chock only one)  1  Certifying Ph 2  Medical Exam	ysician: To the be nimer: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tire	ne, date and pinion, deal	d place, th occurr	and due to the ed at the time,	cause(s) date and	and mai place, a	nner as s and due to	taled. o the cause(s)
To ti withi To ti camp	Σ	29b. Signature and title of certifier	2/					e number			_	_		Day, Year)
15		30. Name and address of person who	completed cause of	of death (Ite	т 23а) (Туре,		) 14	620		7	Ja	n	4, 5	007
St Regist	ate rar	31. Date filed (Month Pay, Pearly 2	007 <sup>32</sup> legi	strar's Sign	ature	onal.	l de suis p			3-1-66	e en	- C#3		7 21701

		1	For State Registrar	State of Marylar		artment of rtificate of		Re	eg. No.	01183
	/sicia	n	Decedent's Name (First, Middle, Last     ELEANOR JUNE					2. Date of Deat Month 1 / 1 / 2	Day Year	3. Time of Death 0705 a <sup>M</sup>
	ledica amine	1.000	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deat		4c. County of Deat	
	- 3 <u>1</u> -		Garrett County	Memorial Ho	spita.	l Oakl	and		Garret	:t
Fune Direc			5. Social Security Number  6. Se 232-42-3919  Usual Residence of Decedent	x 7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 6 / 4 / 1	9. Bird Co	hplace (State or Foreign buntry) WV
land ow	12	-	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation	<u> </u>			10d. Inside City Limits
Mary ⊩f ∎h		ō	WV Presto	on Te	erra A	Alta				XIXYes 2 □ No
th the	DOUG	lre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
ath w	MBLE	la	314 Adair Str	eet		2676			U.S.	
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mantal Hygiene. If tem 27 is marked other than "natural", or Items 23a or 28a-1 show	Xaminer m	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marned  3€3√Vidowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes \$13 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
2 hou	200	te d	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Business/	
21215-0036 solution 72 hours afficiene. er then "naturel", or	No.	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	life.	DO NOT use retire				
ed wi	3	5	12	2	Assi	stant	libraria		Libr	ary
and Ibe fil	•	m	17. Father's Name (First, Middle, Last)	17 - 7				ne (First, Middle, A		
hould d Mer	natic	<u> </u>	Joseph Marsha  19a. Informant's Name/Relationship (Ts		10b Mailie	a Address (Stree			nia Mess	
ore, Maryland is 1 and 2 should be flie of Health and Mental Hy ltem 27 is marked oth	other trau		Sharon June Ha	skiell	100		nt Avenu	e, Terr	City or Town, State, 2 a Alta, 2 20c. Location - City or	WV 267 <sub>64</sub>
TOO	7 0		1  Burial 2  Cremation 3  F 4  Donation 5  Other (Specify)	tornovar norn State		natory or other pla .ta Ceme	1 1 / 4	/2007		
Baltimore, permit. Pages 1 ar Department of Hea Important: if Item	i i	1	21. Signature of Funeral Service Licens		22	Name and Addr	ess of Facility		Terra Al	ca, wv
<b>0</b> 88 E	SDC		* Katherine &	lucitier	1 1	rthur H 05 Hig	H. Wrigh	t Funer	al Home ra Alta,	WV 26764
Physic			23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line. Pneumonia	h. Do not ent	er the mode of dy	ing, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death 2 days
/Medi Exami			resulting in death)	Due to (or as a conseq						de estate
pen	usu.	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq		cancer				) yrs.
58760, icate be executed physicien and		ТХа	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
Box 6 death certif	or use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 mentins? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	Ectopic pregnance Other (specify)	y		23d. Date of deli Month	ivery Day Year
ecords, P.O. law requires that the es been signed by th	e dela	Dy PC	Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord requir	pinol :				<del>,</del>			1 ☐ Ye	s 2 □ No 3 □ Pro	obably 4 Unknown
C et es	bage.	Completed						24a. Was ar autopsy perform 1  Yes 2	prior to d	topsy findings available completion of cause of 2☐ No
of Vital F Physician: Th rithis certificate		מ	25. Was case referred to medical examiner?	lospital:		1.04	hor	th Check only one		
Vision of Attending Physic death.	a runeral di	ation: 10	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	4   Nuising n	ome 5 Reside 28d. Describe ho	nce 6 □Other (Spec w injury occurred	cify)
5 5 5 5	ut for un pa	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, office		28f. Location (Str. City or Town	eet and Number or Ru , State)	ral Route Number,
To the Hospital within 24 hours a To the Funeral Control of the Co	in Vieteidi	edica	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in my	opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
To To 1	00	Σ	29b. Signature and title of certifier	La		29c. Licen	se number	29	d. Date signed (Month	n, Day, Year)
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Tyne	Print)	. 1 2 3 )		11110/	
	1	b	Thomas G. John	son M.D., 3	11 N.		Street	Oaklar	nd MD 2	1550
Reg	State gistra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Look				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ρ. Fields, Sr. 2007 4:50AM January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, ) **July 23,** 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1921 Maryland Months **X**□ M 2□ F 85 218-05-8458 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Maryland Wicomico Salisbury Director TX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or ? must be r 21801 720 Olivia Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines 1 PYes 2 No If Yes, Give Year or Dates: 42-46 1 Never Married 2 Married 1 ☐ Yes 🔼 No **Black** Specify: Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Ministry Pastor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oris G. Fields Margaret Whaley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cresandre Barkley/Daughter 515 N. Curlew Road, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Johns Church Cem. 01/06/07 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Laurel. Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licenses 7. Michael Esken 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can e on each line. Immediate Cause (Final **Physician** THERSCLEST! disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-tra Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 DEctopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by TENSUL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy perform certificate I 1□ Yes 2/2/No 25. Was case referred o medical examiner? funeral director, Be 26. Place \_\_\_ eath Check onl one Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Accident investigation 1 Yes 2 No Could not be determined 3 ☐ Suicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician: or Attending Hospital

3altimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director: filled in by the

> State Registrar

completely

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 ☐ Homicide

(Check only

29a. Certifier

JAN 0 9 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maesha Thimmarayappa M.D. 32. Registrar's Signature \$000 and

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

614 Easternshore Dr Salisbury MD 21804

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7, 2007 January  $A^{M}$ Andrea Lee Gaski 9:13 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fort Washington Hospital Fort Washington Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K T F Yrs. Director 56 16, 309-52-9407 1950 April Indiana Usuel Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itama 23e or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Virginia Arlington None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1601 S. Walter Reed Drive Apt. 22204 U.S.A. by Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 M Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. FISH & WILDLIFE filed within 7 Hygiene. other than College (1-4or 5+) Elementary/Secondary (0-12) U.S. GOVERNMENT BIOLOGIST MANAGER 12 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental H I Item 27 is marked oth Be ၉ Walter Harry Gaski DOROTHY MARIAN MACEDO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46307 19a. Informant's Name/Relationship (Type, Print) DOROTHY GASKI-MOTHER 765 WEST ELIZABETH DR., CROWN POINT, INDIANA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny Injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITIAN CREMATORY 1-12-07 ALEXANDRIA, VIRGINIA MO047922. Name and Address of Facility 21. Signature of Fameral Service Licensee RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 2 No 2 □ No 1 ☐ Yes 1 ☐ Yes of Vital Physician: 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dther (Specify) 1 Yes 2 No 2ER/Outpatient 2 3 DOA this is After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification; Division Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director; completely filled in by the f 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

0, State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3001 Registrar's Signature 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryland / De	epartment of Certificate of		Mental Hy	giene Reg. No.20	07 01186		
	Physici /Medi		1. Decedent's Name (First, Middle,		BBONS			2. Date of D Month	eath Day	3. Time of Death Year 2007 1258 PM		
	Examir		4a. Facility Name (If not institution, UNION MOSO)	The second	per)		or Location of Dec		4c. County	y of Death		
	Funeral Director		5. Social Security Number 193–32–6645 Usual Residence of Decedent	5. Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs. last birth)	Months Days	If Under 24 Hi Hours Mir		irth Pay, Year) 1941	9. Birthplace (State or Foreign Country)		
	Maryland I show	tor	10a. State 10b. County MD CECIL		10c. City, Town of EARLEV					10d. Inside City Limits 1 ☐ Yes ② No		
	th with the 23a or 28a ast be not	al Director	10e. Street and Number 90 DELAWARE AV	Έ.		10f. Zip Code 2191	9		10g. Citizen of	What Country?		
936	72 hours aftar daath with tha Maryland natural', or Itema 23a or 28a-f show ulsal Examirier must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceded Armed Force d 1 Tyes 2 If Yes, Give Year or Date	es? [X]No	13. Was Decedent of II Yes, specify Cub 1 ☐ Yes 2 ☒ No		(Specify Yes or Nerto Rican, etc.)		ce - American Indian, ick, White, etc. fy: WHITE		
21215-0036	within 72 ho ana. then "natur he Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	Education grade completed) College (1-4	or 5+)	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire CHITECTURI	during most of ward)	*	16b. Kind of B	Business/Industry		
Maryland 2	be filad stal Hygi od other event, i	To Be Co	17. Father's Name (First, Middle, La JOHN JOSEPH COY		1211		18. Mother's Na	ame (First, Middle	a, Maiden Suman	ne)		
	s 1 and 2 should f Haalth and Man item 27 ie marke other traumatic		19a. Informant's Name/Relationshi JOSEPH PATRICK		USBAND 90	nailing Address (Street DELAWARE		RLEVILE,				
Baltimore,	it. Page rtment o rtent: if njury or		20a. Method of Disposition  1 ☑Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe  21. Signature of Funeral Service Li	ecify)	ate cemetery,	isposition (Name of crematory or other pla CEMETERY  22. Name and Addre	01/	Date 05/2007	GALENA	- City or Town, State		
Ba	Dapa Impo any ii		23a. Part 1. Enter the disease, or control of th	uple:	sed the death. Do not	FELLOWS, 130 SPEE	HELFÉNB R ROAD,	EIN AND CHESTERT	NEWNAM I	FUNERAL HOME 21620		
8760,	Physician /Medical Examiner physician and physician and physician and the print physician and physician and physician and physician phys	Ical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sacuentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	n line.	rlied,		rpopa		Interval Between Onset and Death		
P.O. Box 68	death cartific a attending p id for usa as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
	aw raquiras 1s been sign 2 should be	Completed by PI	Part II. Other significant condition  Plurch e  - of chi &m	s contributing to deat	1 / -	_	ven in Part I.	1 1 2 24a. Was	Yes 2 □ No	tribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available		
ital R	sician: Tha law s cartificata has b liractor, page 2 si	Be Com	25. Was case referred to medical examiner?				26. Place of De	auto perfet 1 Yes	ormed? 6	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	or Attending Phy Itar death Virector: After this n by the funeral o	Certification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	28a. Date of I (Month, tion t be 28e. Place of	atient 2 ER/Outpa njury Day Year) 28b. Tim Injury - At home, farm, etc. (Specify)	ry M 1	er: 4 ☐ Nursing ry at rk? Yes 2 ☐ No		how injury occurr	eer (Specify) red Per or Rural Route Number,		
	To the Hospital of within 24 hours at To the Funaral Completely filled in	edical Ce	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the be arriner. On the basis and manner	est of my knowledge, dissort examination and/orstated.	eath occurred at the tile or investigation, in my o	me, date and plac opinion, death occ	e, and due to the surred at the time,	cause(s) and ma date and place, a	anner as stated. and due to the cause(s)		
)	To the To the Comp	M	29b. Signature and title of certifier  Cumila	fuer"	MD.	29c. Licens		130		d (Month, Day, Year)		
	Sta	te	30. Name and address of person when AMITA  31. Date filed (Month, Day, Year)	ULI U	ol death (Item 23a) (Type Property (Item 23a) (Type Property (Item 23a) (Type Property (Item 23a) (Type Property (Item 23a) (Type Property (Item 23a) (Ite		-, EL	KTON	, Mi	> .		
DHI	Registr	ar	JAN 4	2007		Soul!						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death **Physician** 2007 Grover Lee Hawkins January 10:24 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 52 Fifth Avenue Ceci1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 15 M 2□ F 212-30-9282 Maryland Director 74 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "naturel", or items 23s or 28s-1 show treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐No Director Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 52 Fifth Avenue 21921 United States Funera 12. Was Decedent Ever in U.S. Amped Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Date US Marines 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 11 Vice President Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked eny injury or other treumatic eveny injury or other treumatic events. Victor Fielder Hawkins Mabel Edith Lucille McCreary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley J. Weaver / Sister 71 Mount Oliver Road, Rising Sun, Maryland 20a. Method of Disposition

12 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January Union Cemetery Elkton, Maryland 4 □ Donation 5 □ Other (Spenity) 5, 2007 21. Signature 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nyocardia Physician Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Oronaru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of): Examiner certificate be executed burial-transit that initiated events resulting in death) Last ding physicien and Due to (or as a consequence of): Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No this certificate 1□ Yes 1 ☐ Yes 2 ☐ No After this certification, funeral director, Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0033925 d address of person who completed cause of death (Item 23a) (Type, Print) 10+1VA 9 Queen Street Ruing Sun S MD Invester 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

IAN 0 4 2007

	Dh. aiai		1- For Amend Item 31 Registrar per WCHD/DV  1. Decedent's Name (First, Middle, Last)	7 === = 7 = 0   0	ertificate of Death		J. No.
	Physici /Medio			lart		Januar	y 4,2007 4:57 AM
	Examir	ner	4a. Facility Name (If not institution, give 12367 Big Pool		4b. City, Town, or Location of Death		4c. County of Death
	Funeral		5. Social Security Number 6. Sec		Clear Spring  of If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washington  9. Birthplace (State or Foreign
	Director			M 2X F 71 Yrs.	Months Days Hours Min.	Sept 9	Country MD
	and *	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation		10d. Inside City Limits
	Maryli f sho	ē	MD Washing				1 ☐ Yes 🌠 No
	h with the	Funeral Director	10e. Street and Number 12367 Big Pool	Road	10f. Zip Code 21722	10g	g. Citizen of What Country?
9800	be filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. dethygiene. dether than "natural", or items 23e or 28e-f show other than "natural", or items 23e or 28e-f show event, I've Medical Exactinal must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Pueno 1 ☐ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specifiwhite
121	_ = 30	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th grade	cation 16a. Dec (Giv life) 16 College (1-4or 5+) H	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) OMEMAKET	ing 16	sb. Kind of Business/Industry
73	2 should be filed withlr and Mental Hygiene. Is marked other than aumatic event, the Ms	To Be C	17. Father's Name (First, Middle, Last)	pert Mellott		e (First, Middle, Ma a May Mo	
	5 € 7 ±		19a. Informant's Name/Relationship (Ty Charles W. Hart		ing Address (Street and Number or Run 67 Big Pool Rd.	Clear S	City or Town, State, Zip Code) Spring, MD 21722
	Page ento nt: If ry or		20a. Method of Disposition  1 XBurial 2 Cremation 3 R  1 Donation 5 Other (Specify)	emoval from State 20b. Place of Disposition Commetery, critical Shankto	osition (Name of ematory or other place) wn Cemetery 20	• •,	c. Location - City or Town, State Big Pool, MD
Balt	permit. Pa Departmen Importent any injury once.		21. Signalue of Funeral Services License				Funeral Home, Inc
	-nysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		ndent Dabetes		Interval Between
	cate be executed XX  hysicien and important the burial-transit entry	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	ndent Dabetes	s Mellit	vs years
.O. Box 6	the death certific y the attending p iched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	The law requires that tte has been signed b page 2 should be deta	þ	Part II. Other significant conditions cor	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	cco use contribute to the cause of death?
		Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Vita	Physician: The this certificate ral director, pag	Be	25. Was case relerred to medical examiner?	ospital:		(Check only one)	
of	ling I. After Tune	ıtlon; To	1 Yes 2 No  27. Manner Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  2 ER/Outpatie 28b. Time		me 5 Residence 28d. Describe how	ee 6 ⊡Other (Specify) injury occurred
É	i Dite	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, lactory, office	281. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	24 h 24 h Fur etely	Medical	one)	ician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated	ivestigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
4	To the comple	2	29b. Signature and title of certifier	Jeso mo	29c. License number MD 005213	ماه	Date signed (Month, Day, Year)
	5		30. Name and address of person who co	11111	1 D = 111111	sport my	D 21795
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	32. Redistrar's Signature	Sperker		

		1 - For State Registrar	State of Ma	ryland			of Health ar of Death	nd Mental H	ygiene Reg. No	211111	0118
Physicia	an	1. Decedent's Name (First, Middle, Last	Florence	בו פי	nev			2. Date of I Month	Da		3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give		<i>y</i> C 00	псу	4b. City, Tov	m, or Location of Solomor	Death	Jan 2, 2007 2:20 A  4c. County of Death  Calvert		
Funeral Director		5. Social Security Number 167-28-1155  Usuel Residence of Decedent	х ]м 2 <b>X</b> ]F	(In yrs. Ia.	st birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 ays Hours	Min. (Month, I	Birth Day, Year) 1, 1907	9. Birth Cou	place (State or Fore ntry) Maryland
la-f ehow	ctor	10a. State 10b. County  MD Calv	rert	10c. City,	Town or Lo	cation	Lusby				10d. Inside City Limi
3a or 2u	I Dire	10e. Street and Number 9490 H. G. Trueman Road	ı			10f. Zip Co	de 20657		10g. Cit	izen of What Cou U.S.A	•
골체	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Nover Married 2 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 N N If Yes, Give Year or Dates:			Vas Decedent f Yes, specify		n? (Specify Yes or I Puerto Rican, etc.)	r No- ) 14. Race - American Indian, Black, White, etc. Specify: Black		
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od othe	To Be Co	17. Father's Name (First, Middle, Last) Willia	am Claggett Je	fferson					artha F	lutchins	
th and 7 is n treun	H	19a. Informant's Name/Relationship (T) Bobby Janey/son	/pe, Print)					or Rural Route Num Lusby, MD 20		or Town, State, Zi	p Code)
tent: if Item jury or other		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		cer	netery, cren	sition (Name of natory or other IMC Ceme	place)	Date 01/06/07	20c. Lo	ocation - City or T Lusby,	
Depertm Importar eny Injur		21. Signature of Funeral Service Licens Sladyp a.	Server	0	22	Sewel	ddress of Facility I Funeral Ho Dares Beach	me Road Prince	Freder	ick. MD 206	78
e eattending physicien and water fransit dor use as the buriat-transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a d.	SC/19	ence of): 10 H C ence of):	Arrh	y Himi io Vasu	ilar di	5 8 685 (	2	Onset and Death
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signe d be c	þ	Part II. Other significant conditions co		t not result	ting in the u	nderlying caus	e given in Part I.		tobacco u		the cause of death?
page 2	Completed	Diahetes me Periphenal	Vascula	77_ °	Disec	se		24a. We aut per 1	topsy formed?	prior to co	opsy findings availa impletion of cause of
certiticate	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	۰	0/0			Death Check on		27-	
within 24 hours after death.  To the Funeral Director: After this certifice completely tilled in by the funeral director.	atlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	/ 2	28b. Time of Injury	28c.	Injury at Work?	ing Home 5 ☐ Re 28d. Describ	sidence e how inju	y occurred	<b>n</b> y)
rs after der ral Direct	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	(Specify)				City or T	own, State	)	al Route Number,
n 24 hours a he Funeral I pletely tilled	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best o ner: On the basis of and manner stat	examinatio	ledge, death on and/or in	occurred at the control of the contr	ne time, date and my opinion, death	place, and due to th occurred at the time	e cause(s) e, date and	and manner as a place, and due t	stated. o the cause(s)
withi To tl	M	29b. Signature and title of certifier	c. Su	~ a	n,		5065	3		te signed (Month,	
١.		30. Name and address of person who co	e Chwr				YAIY (	e SURI	ONA		

			For State Registrar	State of	f Marylan		artment ortificate			and Me		Em	.007	01190
4			Decedent's Name (First, Middle	[ast]			imouto	0. 0	- Catir		2. Date of Dea	Reg. No	).	3. Time of Death
	Physici	an	_								Month	Da		
	/Media	al	Eugene R. Mac								Januar	-	l, 2007	2:30 P M
1 45	Examir	er	4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, To	wn, or L	_ocation o	of Death		4c	. County of Deatl	1
		13 to	319 East Potom	ac Street					swicl			Frederick		
N	Funeral	-0.57	5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs.		If Under 1 Months [	Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da)	h v. Year)	9. Birth	nplace (State or Foreign untry)
	Director		217-28-6782	1MM 2LJF	73	Yrs.	oriano	Juys	110013		June 26			vland
	P .		Usual Residence of Decedent											
	rylar how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Ma Per	io	Maryland Frede	rick			Brunsw	zi ck						1X Yes 2 No
	1 28 L	Director	10e. Street and Number				10f. Zip C					10g. Cit	izen of What Co	untry?
	3a o	0	319 East Potom	ac Street				21	716			Π'n	nited St	atos
	leath Ins 2	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.	Was Deceder			gin? (Spec	ofv Yes or No		14. Race - Ame	
	Her I	5	1 ☐ Never Married 2 ☐ Marri	Armed Fo	rces?		f Yes, specify	Cuban	, Mexican	, Puerto F	offy Yes or No- Rican, etc.)		Black, White	
36	is in	b	3 Widowed 4 Divorced	If Yes, Giv Year or D	/e		1 ☐ Yes 2 🔀	No	Specify:				Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show ta Modical Evanit or Livel to rodified at	ed	15. Decedent			16a Dece	dent's Usual (	Occupat	ion			16h K	ind of Business/l	nductor
5	n 72	Completed	(Specify only highes			(Give	kind of work	done du	iring most	t of workin	g	100. 1	and or businessy	ndustry
12	with:	ᄩ	Elementary/Secondary (0-12)	College (1	-4or 5+)	Mete		ader					Electri	0.01
	led tygic her nt, II		12 17. Father's Name (First, Middle, I			Mete	er Kee							.cai
Ĕ	tail H	Be	Unknown	.ast)							(First, Middle,	_		
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Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, us Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (S	Street ar	nd Numbe	er or Rural	Route Numbe	er, City o	or Town, State, Z	ip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygene . If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, If a Mystical Era pile fraumatic event, If a Mystical Era pile is the context.		Sylvia Pudo	y / Daugh	iter	1	317 E.	pot	omac	Stre	eet, Br	unst	wick, MD	21716
5	S 1 2 f He fterr oth		20a. Method of Disposition			Place of Dispo cemetery, crer	sition (Name	of			ate		ocation - City or	
μ	Pages nent of I ant: If It		1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		State   _	esthave		ar prace,		1/8/2	2007	F	rederick	, Maryland
Baltimore,	2 E E E		21. Signature of Funeral Service I				2. Name and	A ddrasa						
Ba	Depermine Deperm		1.	7.7	11					,			Funeral	
			1 out they	Jai	ffer								wick, MD	21716
67		į.	23a Part 1. Enter the disease, or shock, or heart failure List	complications that confidence on a	sused the deat ach line.	h. Do not ent	er the mode of	of dying,	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ma s	111		eria.	10	19			Onset and Death
	/Medical		resulting in death)	Due to (	or as a conseq	juence of):	C 6/		/					27 70
	Examiner													
	140	er	Sequentially list conditions, if any, leading to immediate	Due to (	or as a conseq	uence of):				-		-		
	utad I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury											
	cate be executed physician and the burial-transit	xa	that initiated events resulting in death) Last	C. Due to (	or as a conseq	uence of):								
8760,	be ciciar buri	aiE												
87	cate phys	dicai		d										
9	ling ling eas	Me	IF FEMALE:					-						
Вох	ath c Itend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1 ☐ Live b	irth 2 Feta		Ectopic preg	nancy					23d. Date of deli	*
	a de a e de	Sici	1 ☐ Yes 2 ☐ No	4☐ Pregn	ant at time of d	leath 5	Other (spec	ify)					Month	Day Year
P.0	at the by the	Physician/Me	9 Unknown	3CJ OTIKI							T			
	The law requires that the death certify ale has been signed by the attending page 2 should be delached for use as	by F	Part II. Other significant condition	ns contributing to de	eath but not res	utting in the u	nderlying cau	se giver	n in Part I.		23e. Did to	bacco	use contribute to	the cause of death?
Records,	quire n sig uld b	D P	COPI	5	7 401	7000	C:	211	-	Cy	150	es 2	□No 3□Pro	bably 4 Unknown
<u>o</u>	w requir been si should	Completed	< /								24a. Was		Tan	
36	has has	E C	0419								autop		prior to c	topsy findings available ompletion of cause of
_	: The l	ပိ									1 ☐ Yes	2 No		2 🗌 No
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					-		of Death	(Check only o	ne)		
of	\$ 5 D	ို	1 Yes 2 No	Hospital: 1 🗆 I	npatient 2 🗌	ER/Outpatier	t 3 DOA	Other	4 ☐ Nui	rsing Hom	ne 56 Resid	lence	6 Other (Spec	ufy)
0	ding Ph h. After th funeral		27. Manner of Death  1 Autural 5 Pending	28a. Date of	of Injury th, Day Year)	28b. Time of	28c	. Injury a	at	2	8d. Describe h	ow inju	ry occurred	
ō	ath.	atic	2 Accident investig		, ,	,,	М		es 2 🗆 N	No				
Division	Att de octo	ific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned   200. Flace	of Injury - At h	ome, farm, str	eet, factory, o	office		2	8f. Location (S	Street ar	nd Number or Ru	ral Route Number,
ā	afte Dir din	ert	4 [] Homeda	Duildii	ng, etc. (Specit	<b>Y</b> )					City or Tou	m, State	9)	
	To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical Certification:	29a. Certifier 1 Certifyin	Physician: To the	best of my kno	owledge, deat	n occurred at	the time	a, date and	d place a	nd due to the	cause/r	) and manner co	stated
	24 h 24 h Fui etely	dic	(Check only 2 Medical E	xeminer: On the ba	asis of examina	ation and/or in	vestigation, in	my opi	nion, deat	th occurre	d at the time,	date and	d place, and due	to the cause(s)
	ithin o the	Me	29b. Signature and title of certifier	and main	,		29c I	icense	numher			29d Da	te signed (Month	Day Year
	E 3 F 8			>							1			
	M.			<u> </u>	2	ins	1	7/	46	26		Jo	n 4.	2007
15	UKILL		30. Name and address of person v	vho completed caus	e of death (Iter	п 23а) (Туре,	Print)		,	,			,	
1	<u> </u>			364 1	mp.	501	wi	1 5	50	1	-red	7-10	3 M	2007
11)	Sta	ite	31. Date filed (Month, Day, Year)	32.	gistrar's Signa	ature								
	Registi	ar	JAM 0 5	7007   27	100,00	K A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7

			1 - For State Registrar	State of Maryland		ite of Death		Reg.	Error Col. July 1	01191
	Physici /Medic		1. Decedent's Name (First, Middle, Las EDGAR HO	FFMASTER	MCE	RATH		Date of Death Month	Day Year 4 2007	3. Time of Death 8:04 AM
)	Examir		4a. Facility Name (If not institution, give			y, Town, or Location			4c. County of Deat	th
	Formula		Genesis Health  5. Social Security Number 6. S			Eastor ler 1 Year   If Under		Date of Birth	Talbo	thplace (State or Foreign
	Funeral Director			om 2□F 73	Yrs. Month		Min.	Date of Birth (Month, Day, Y)	933	mD Orang
	yland		10a. State 10b. County	10c. City, 7	Town or Location					10d. Inside City Limits
	8a-1 s	Director	MO TALB	IT LAS	>10N					1 Yes 2 No
	hours after death with the Maryland turs!', or itsms 23a or 28a-f show all Examinst must be notified at	al Dir	201 FEDERAL	STREET #	77	2160	1	10g	. Citizen of What Co	untry?
	itsms	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was De	cedent of Hispanic Or pecify Cuban, Mexica	rigin? (Specify an, Puerto Ric	Yes or No- an, etc.)	14. Race - Ame Black, Whit	
036	ours aft	þ	3 Widowed 4 Divorced	1 Pres 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify	r:		Specify: W	HITE
1215-0036	2 2 3	ietec	15. Decedent's Ec (Specify only highest gra		6a. Decedent's U	sual Occupation work done during mo- use retired)	st of working	16	b. Kind of Business/	Industry
212		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ACCO	UNTAL	IT	F	ACCOUN	TING
and 2	og ta be €	Be	17. Father's Name (First, Middle, Last)	ASTER MEGRA	TH SO	18. Moth	ner's Name (F	irst, Middle, Ma.	iden Sumame)	
ary	and and is m	ဥ	19a. Informant's Name/Relationship			ess (Street and Numb	per or Rural R	oute Number, C	City or Town, State, 2	Zip Code)
e, S	1 an Heal em 2 ther		20a. Method of Disposition	WIFE 20b. Plac	201 FEDE a of Disposition (A	RAL STRE	ET # 7	7 EAS	c. Location - City or	21601 Town, State
Ē	of of		1 Burial 2 Fremation 3 4 Donation 5 Other (Specific	Removal from State	etery, crematory o	r other place)	01/05	107 1	DOVER.	DE
Baltimore	permit. Pag Department important; sny injury o		21. Signature of Funeral Service Licer	isee	22. Name WILLI	and Address of Face AMSON F MAIN ST.	UNEX	AL HOY	NE PG MO	71/-27
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. one cause on each line.	Do not enter the m	ode of dying, such as	s cardiac or re	spiratory arrest		Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequer	515					Onset and Death
	Examiner		Sequentially list conditions	b Men Ma		nluc	Man	wint.	ection	done
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Que to (or as a consequer	nce of):	1/1.	for tile	n	, , , , , ,	1/2.00
ó	icete be executed physicien and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequen	nce of):	30,1.	1/11	1.		yeary
68760,		edicai		d. 0/3/12	mer	1 DEV	Mcn,	MA		Year
O. Box (	death ce e ettendir id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic				23d. Date of del Month	ivery Day Year
s, P.	es that the greed by be detac	by Ph	Part II, Other significant conditions of	ontributing to death but not resulti	ng in the underlyin	cause given in Part	ı.	23e. Did tobac	co use contribute to	the cause of death?
ords	w require been sig should b						_	1 🗆 Yes	2 No 3 □ Pr	robably 4 Unknown
Vital Record	The law requires that the sete hes been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
ital		0	25. Was case referred to medical			26. Plac	e / eath (C	1 ☐ Yes 2 ≥ 2 heck only one	No 1 ☐ Yes	2 □ No
of <	Physician: this certific ral director.	To B	examiner? 1 Yes 2 No		VOutpatient 3		lursing Home	5 Residence	e 6 Other (Spe	cify)
ono	D e	tlon:	27. Man of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Bb. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		. Describe how	injury occurred	
Division	al or Attandi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fact	ory, office	28f.	Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
_	Hospit 4 hour Funera ely fills	Medical C	29a. Certifier 1 Certifying Ph	nysician: To the best of my knowle wither: On the basis of examination and mapped stated.	edge, death occurre a and/or investigati	ed at the time, date a on, in my opinion, de	nd place, and ath occurred a	due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Vithin 2	Me	29b. Signature and title of certifier	XXX MI	> 2	9c. License number	בת ייים	29d.	. Date signed (Mont	h, Day, Year)
				14		D 60 73		(	14/07	!
			30. Name and address of person who	completed cause of death (Item 2:	3a) (Type, Print)	NED AV	(Ned	EN	In MA	2166
1	St	ata	31. Date filed (Month, Day, Year)	/ 32. Registrar's Signatur	0			7 . 10	1 1	01001

DHMH 17 Rev 1/2001

Registrar

	_	For State Registrar	State of M	arytar		rtificat					Reg. No.	.007	UIIJ
Physicia	an	Decedent's Name (First, Middle, Last			~ ·					<ol><li>Date of De. Month</li></ol>	Day	Year	3. Time of Death
/Medic			erine Jone		Guire					Januar	1	2007	8:15 p
Examin	er	4a. Facility Name (If not institution, give			-01	4b. City,		Location				ounty of Death	
		Fairfield Nursing & R 5. Social Security Number 6. S				If Under		OWNSY If Under	7ille	0.0		Anne Ar	
uneral irector		216-12-6546	9X	85 85	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da Oct • 9,	y. Year) 1921	J. Birth	place (State or Forei Intry) laryland
ž	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation		-					10d. Inside City Limi
lifted a	ctor	Maryland Cec.	i1				Perr	yvill	Le				1⊠Yes 2⊡N
3a or 28	Funeral Director	10e. Street and Number 24A Owens Landing	g Court			10f. Zip	Code	2190	)3	0 0 0 0	10g. Citize	U.S.A.	-
ma 2	Jera	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Deced	dent of Hi	spanic Or	igin? (Spe	city Yes or No Rican, etc.)	- 14	. Race · Amer	
Depositions or results but wester regions.  The many injury or other traumatic event, the Madical Examinat must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces  1 ☐ Yes 2 ☑  If Yes, Give  Year or Dates:		ĺ	ir Yes, spec 1 ☐ Yes				Hican, etc.)		Black, White pecify:	White
Sale	Completed	15. Decedent's Ed	lucation		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind	of Business/I	ndustry
Mad	ple	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	(Give	kind of wo DO NOT u	rk done d se retired	<i>luring</i> mos ')	it of workii	ng		-	al Training
4	E O	Ten Years			Superv	isory	Accou	nting	Techn	ician	Baink	oridge,	Maryland
vent vent	Be (	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle,	Maiden Si	umame)	
rked tice	10	Geo	rge R. Jo	nes						Harrie	tte E	klund	
		19a. Informant's Name/Relationship (	Type, Print)							Route Number			
n 27		Ruth Ann Donovan	(Daughte:	-				Trai	1, C	rownsvi	lle,	Maryla	nd 21032
E E		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐	Damaual from State	1 4	Place of Disponentery, crea	natory or o	ne of other plac	e)	D	ate	20c. Loca	ition - City or 1	Town, State
ury o		4 ☐ Donation 5 ☐ Other (Specif		St	. Mark	's Cer	mete	ry	01/0	5/07	Perry	ville,	Maryland
Importa		21. Signature of Funeral Service Licer	1000 811	S. W	Le Le		Pat	terso	n & :	Son Fun			P.A.
ettending physicien and personal for use as the burial-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if all y, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	s a consec	quence of):	×ac	Cer	Ŋai	1701	1			Interval Between Onset and Death
igned by the ettending posteriors be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	23c. If yes, outcom 1∐Live birth 4∏Pregnant a 9∏Unknown	2 Feta	al death 3	⊒Ectopic pr ⊒ Other (sp					23	d. Date of deliment	very Day Year
signed b	d by Pt	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlying c	ause give	en in Part	l.		obacco use		the cause of death?
cate has been sig page 2 should b	Completed									24a. Was autor perio	osy irmed?	prior to c death?	topsy findings availat ompletion of cause of
certificate rector, pag	0	25. Was case referred to medical						26 Place	e of Death	1 Yes		1 🗌 Yes	21XN0
8 E	To B	examiner? 1 ☐ Yes 2 ❷ No	Hospital:	ient 2	ER/Outpatie	nt 3 DC	Othe	0.00		ne 5 ☐ Resi		Other (Spec	ufv)
ter th	tlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio	28a. Date of Inj (Month, D		28b. Time o		28c. Injury Work		- 1	28d. Describe			,
within 24 nours ariel deain. To the Funeral Director: All completely filled in by the fu	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		njury - At h etc. <i>(Speci</i>	ome, farm, st					28f. Location ( City or To	Street and wn, State)	Number or Ru	ral Route Number,
Funera Funera etely fille	Medical (	29a Certifier 1 Certifying Pt (Check only 2 Medical Exer- one)	niner: On the basis and manners	of examina	wladge, deal ation and/or in	h conurred vestigation	at the tin i, in my or	ia data a pinion, dea	nd place is ath occurre	ind due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
omple omple	₹.	29b. Signature and title of certifier?				290	c. License	number			29d. Date	signed (Month	, Day, Year)
s⊢ō		<ul> <li>886</li> </ul>	es MD			1	11).	591	198			3/07	
		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type,	Print)	Tou	CNA	MI	71	181		
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		200 W AL 2	L/LE_J	~ :	11700	7001	1 11	/ ~ 1	- (1 1 ·	<b>つ</b>	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** CARL LEVAN MILLER 2007 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year 8. Date of Birth (Month, Day, Year) MARCH 22, 1925 Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours 1**X** M 2□ F Months Days Min. 220-18-3379 Director 81 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MARYLAND WASHINGTON BOONSBORO 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 FORD AVENUE 21713 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1943-17 Yes 2 No 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1945 1 ☐ Yes 2 ☐ No ρ Specify Specify: 3 Widowed 4 ☐ Divorced Year or Dates: WHITE "natural", Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event them. ASSEMBLER AIRCRAFT MANUFACTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAMAN SAMUEL MILLER MARY PEARL GETLMACHER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>JEFFREY A. MILLER, SON</u> 17229 AMBER DRIVE, HAGERSTOWN, MARYLAND 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) ROSE HILL CEMETERY 1/9/2006 HAGERSTOWN, MARYLAND 21. Signature Fun ral Sen toe Licensee 22. Name and Address of Facility
BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hours /Medical Due to (or as a consequence of) Examiner OUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page perform certificate 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation Year) reral Director: A death. 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier

*♦H − 7+1* State

Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

**JAN 05** 

1138

32. Registrar's Signature

hysicia	an	Registrar  1. Decedent's Name (First, Middle, Last  ELIZA METILA	*	EWMAN	rtificate of		2. Date of Death Month	Day Yeer	3. Time of Death
/Medic	al			LWMAN			JAN. 3	2007	10:00 A
xamin	er	4a. Facility Name (If not institution, give				or Location of Dea	ith	4c. County of Death  QUEEN Al	
neral		359 BROWNSVILLE  5. Social Security Number 6. Se		'In yrs. last birthday)	If Under 1 Yea	r If Under 24 Hr			place (State or Foreig
ector		219-05-0282 Usual Residence of Decedent	□м 2 <b>ஜ</b> F 93	Yrs.	Months Days	s Hours Mir	JAN. 8,		YLAND
ified at	tor	10a. State 10b. County  MD QUEEN A		Oc. City, Town or Lo	REVILLE				10d. Inside City Limit:
DI 78	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
Tight.		359 BROWNSVILLE			216			USA	
narked oner tran hauten, or rema 23e or 26er enow sumatic avent, tra Modical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 😿 No		Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Bleck, White, Specify: BL	etc.
Medical	Completed	15. Decedent's Edd (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of w	orking 16	b. Kind of Business/Ir	ndustry
2	Com	4	-0-		MESTIC	HELP		HOME CARE	
tic aven	To Be	17. Father's Name (First, Middle, Last)  CHARLES ELSWORTH	COOPER				ame (First, Middle, Ma THA HAZELTO	•	
r traumatic		19a. Informant's Name/Relationship (T) MARTHA COOPER—CHE					Rural Route Number, C CENTREVIL		
ry or other		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, crer CHESAPEAN CENTER	natoni or other of	TION 1-4		s. Location - City or To	
any njury or other tra		21. Signature of Funeral Service Lice		22 F1	Name and Add	ress of Facility ELFENBEIN	N & NEWNAM		
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the	ie death. Do not ent	98 S. LI er the mode of dy	ing, such as cardi	CENTREVI	LLE, MD Z	Approximate Interval Between
ician		Immediate Cause (Final disease or condition	Demento	-					Onset and Death
dical niner		resulting in death)	a	consequence of):					12000
miei		Sequentially list conditions,	b. CVA	consequence of):					Years
ısıt	nine	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
al-trar	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a c						7247
the burial-transit	cal		d						
ed for use as the	Physician/Medi	in the past 12 months?	23c. If yes, outcome of 1 Live birth 2   4 Pregnant at tin	Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date of deliver	ery Day Year
be detached	Phy	9 Unknown					One Didashar		h
should be d	by	Part II. Other significant conditions co	ntributing to death but I	not resulting in the u	nderlying cause g	IVen in Part I.		co use contribute to t	ne cause of death?
age 2	Completed						24a. Was an autopsy performed	prior to co death?	opsy findings availat impletion of cause o
ral director, p	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	a∏500:			eath (Check only one)		
funeral d	lion: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	28c. Inju	4 🗆 140(3)(19	Home 5 Residence 28d. Describe how		(y)
d in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, str (Specify)			28f. Location (Stree City or Town, S	t and Number or Rura Tate)	al Route Number,
ely fille	edical C	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of e ner: On the basis of ea and manner state	kamination and/or in	occurred at the vestigation, in my	time, date and place opinion, death occ	ee, and due to the caus curred at the time, date	e(s) and manner as s and place, and due to	stated. the cause(s)
0 0	Me	29b. Signature and title of certifier			29c. Licer	ise number	29d.	Date signed (Month,	Day, Year)
pmpletely	- 1	1//-			3.4	_	. 1	1/	
teldmap		TURNE	Likem in		1162	747	1//	4/0/	
16 John Market		3. If me an address of person who co	ompleted cause of dear	th (Item 23a) (Type,	D 63	247 carreville	no 2161	4/0/	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edna Mae Robinette 7:25 PM January 2 2007 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Devlin Manor Nursing Home Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) April 15 1917 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖫 F Months 89 215-14-6215 Yrs Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV. Mineral Kevser 1XXXYes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 500 Carskadon Lane 26726 United States Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: white 1 Yes 2X No Specify: 2 3 Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Copeland John J. Magruder Emma 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Reall/granddaughter Rt.1, Box 157 A, Keyser, West Virginia 26726 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 01/05/ Bloomington Maryland MBurial 2 ☐ Cremation 3 ☐ Removal from State Bloomington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ulan Examiner Due to (or as a consequence of) Examiner ettending physician end I for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) P.O. Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has certificate 1 Yes 2010 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Aft completely filled in by the fur 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 1)0017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 620212 MD 2/501 AJT&Iline MI 912 Net

32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

JAN

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Terrance Keenan Raleigh State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical Examiner TERRANCE KEENAN RALEIGH Month Day January 8, 2007 1649 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1c. County of Death 101 VFW Avenue Grasonville Queen Anne's 5. Social Security Number 6 Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or oreign Director Months Days Hours 1 X M 2 F 55 JANUARY29, 1951 Country) VERMONT 028-40-7994 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits s 23a or 28a-f show e notified at once. 28a-f show MARYLAND QUEEN ANNE'S GRASONVILLE 1 X Yes 2 Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 OYSTER COVE DRIVE 21638 UNITED **STATES** Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black other traumatic event, the Medical Examiner must he Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married White, etc. Yes Specify: WHITE 3 Widowed Yes 2X No specify. 4 Divorced If Yes, Give Year "natural", ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Itimore, MD 21215-0036 BUILDING INSPECTOR 12 should be filed within and Mental Hygiene. TOWN OF EASTON 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) JOHN PATRICK RALEIGH ALOYSE KEENAN Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code If item 27 is 1302 OYSTER COVE DRIVE, GRASONVILLE, MD 21638 DEBRA WALKER / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State JANUARY 13, NEWBURYPORT crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MARY'S CEMETERY 2007 Donation 5 Other Specify MASSACHUSETTS 0 21. Signature of Funeral Service Licensee HELFENBEIN & NEWNAM 22. Name and Address of Facility **FELLOWS** 106 SHAMROCK ROAD CHESTER, MARYLAND 21619 FUNERAL HOME, P.A., Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Oxycodone and alcohol intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last transi and Physician/Medical use as the bur X UNPENDED **AMENDED** #23a,27,28a-f, perME, g863, 1/23/07 TT Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day past 12 months? Fetal death Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes 25. Was case referred to medical the Hospital or Attending Physician: 26.Place of Death (Check only one) Be Hospital 1 Other<sub>4</sub> this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene 1 V Yes 2 After Manner of Death 28a. Date of Injury (Month. Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural Pendina Yes 2 X No unknown To the Funeral Director: Fnd 1/8/2007 Fnd 4:45 pm 2 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 101 VFW Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined (Specify) motel Μ̈́D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E January 9, 2007 30 Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

State Registrar

DHMH 17 Rev 1/2001

completely

within 2 To the I

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

when

Ludwig J./Eglseder,

32. Registrar's Signature

30. Name and address of berson who completed cause of death (Item 23a) (Type, Frint)

MD

12 15 A

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

503 Cynwood Drive; Easton, MD 21601

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien $oldsymbol{\epsilon}$   $\cup$   $\cup$ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle) Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4c. County of Death Facility Name (If-not institution, give street and numb 4b. City, Town, or Location of Death Examiner aRO nton If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** 1 - M Days Hours Min 2/2 F 219-14-2590 91 Director 23, 1915 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "naturel", or Items 23a or 28a-1 ehow the Midligal Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Denton Maryland Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 Edenton Manor Gay Street United States of America by Funerai Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritat Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Merital Hygiene Important: If Item 27 is marked other than "naturel", or Item eny injury or other fraumatic event, the Modical Examinat once. 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Caucasian Specify: 3 → Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Henry Cronshaw Rosalie Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29568 19a, Informant's Name/Relationship (Type, Print) 462 Colonial Trace Drive, Longs, South Carolina Myrtle J. Dennis Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenshoro Cemetery 1/4/2007 Greenshoro, Maryland 21. Signature of Funerat Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, with 100 Denton, Maruland 21629 23a. Part1. Enter the diseased, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat **Physician** oronari Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2X No 1 Yes filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 42 Nursing Home 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only

State Registrar 29b. Signature and title of certifier

Wafik Zaki, M. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.,

DHMH 17 Rev 1/2001

with the Maryland

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

and

attending physician

the

signed by

peen s

has

After this certificate

within 24 hours after death. To the Funeral Diractor: A

or Attending

Hospital

To the

Anside!

920 Market Street, Denton, Maryland

29c. License number

D0047534

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 5 2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

8

amala Deanne S	ouder State of Maryland / Departme			
		te of Death		2007 0120
Physiciar	Decedent's Name (First, Middle,Last)		2. Date of Death	Year 4500 km
ledical Examin	Tama Ta Deathle Souder	The second second	January 10, 2007	1500 nrs
	4a. Facility Name (if not institution, give street and number) 701 Charles Street	4b. City, Town, or Location of Death  La Plata	4c. Coun	nty of Death
Funeral	Social Security Number			YYY) 9 Birthplace (State or
Director	217-96-8529 1 M 2X F 37	Months Days Hours Min		Foreign Virginia
	Usual Residence of Decedent			
w any	10a State 10b. County 10c. City, Town of	Bowie		10d Inside City Limits 1 X Yes 2 No
daryland 28a-f show 1.at once.	Maryland Prince George's	10f. Zip Code	100 000000	What Country?
th the Maryland 23a or 28a-f she notified at once	12419 Shawmont Lane	20715	U.S	
with the same same so another	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Sp	pecify Yes or No- 14 Ra	ace - American Indian, Black,
death	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) W	hite, etc.
s after ral", o	or Dates:	1 Yes 2 No specify:	Specif	
hours.		ecedent's Usual Occupation (Give kind of vulling most of working life DO NOT use reti		Business/Industry
)36 hin 72 than than		okkeeper	In	surance
215-0036 be filed within 72 ntal Hygene rked other than ont, the Medical			e (First, Middle, Maiden Surna	me)
d be fill ental I arked vent,			Dale Clark	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Mailing Address (Street and Number or 19419 Shawmont Lane,		
and 2 lealth item 2	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery,		on - City or Town, State
Baltimore, sernit Pages I ar Department of Her Important: If tite Injury or other tr	Trini+	y Memorial Gdns. 01/	15/2007 Wald	orf, Maryland
Baltir permit F Departme Importan	21 Signature of Funeral Service Licensee M00053	22. Name and Address of Facility	The state of the s	shington Road
E P P D	Mark G. Brohawn (per DVR)	Huntt Funeral Home	Waldorf, Mar	yland 20601
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.		or respiratory arrest, shock, or	Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Cocaine and oxycodo  Due to (or as a consequence of):	ne intoxication		Death
	Sequentially list conditions, b			
	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlyin, Cause			
ed	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	· · · · · · · · · · · · · · · · · · ·			
	X UNPENDED X AMENDED #21, perFH, 23	a,27,28a-f, perME, g863,		
Box 68760, c death certificate but the attending physical for use as the but	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1	✓ Fetal death 3 Ectopic pregna		e of delivery n Day Year
OX 6 eath ce attend for use	1 V Yes 2 No 9 Unknown 0 Ulakewaya	Other (Specify)		
that the de hed by the detached f	9 Olikhowii	in the underlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death?
Division of Vital Records, P.O ral or Attending Physician: The law requires that to after death  al Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	3	, , ,		3 Probably 4 Unknown
w requires been is been is should				b. Were autopsy findings available
i of Vital Reco			autopsy performed? 1 ✓ Yes 2 No	prior to completion of cause of death?  1 ✓ Yes 2 No
Vital Rec ysician: The I his certificate I director, page	25. Was case referred to medical	26 Place of Death (Check		- Tes 2 No
Nits of the direct	1 Yes 2 No Inpatient 2 FR/Ou		ng Home 5 Residence	6 Other.
n of ding Ph		ime of Injury 28c. Injury at Work?	28d Describe how injury occ	curred
Sior Attenc r death ector: by the	2 Accident Investigation Fnd 1/10/2007 FNd	2:00pm   Tes 2A No	unknown	mhor or Rural Routa Mumhor City
Divi	4 Homicide determined (Specify) residence	mi, or out, factory, office building, etc.	or Town, State) 1125 Waldorf, MD	mber or Rural Route Number, City 5 Perrysville Ct.
E 0 5 4 1	29a Certifier	th occurred at the time, date and place, and		ner as stated
To the Horwithin 24 h To the Fur	one) 2 Medical Examiner:On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date and place, an	nd due to the cause(s)
	29b Signature and title of certifier	29c. License number		igned (Month, Day, Year)
	Jame Jeseful	O.C.M.E.	January	12, 2007
	30. Name and address of person who completed cause of/death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MI	D 21201	
Sta	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, 23		
Registr	7.4	Acordo 3		

DHMH 17 Rev 1/2001 OCME 2006

#21 TIMIKINGS CONFINITIN

			For State	State	of Maryla		artment of F		Mental Hy	200	7 01202
			Registrar  1. Decedent's Name (First, Middle	, Last)			inicate of	Dealit	2 Date of Dea	Reg. No. UU	3. Time of Death
	Physicia		Leo	Edward	Stone	2			Month	Day 200	ear
	/Medic Examin	_	4a. Facility Name (If not institution				4b. City, Town, o	r Location of Deat	-	4c. County of	
			23110 Freder	ick Road			Clarks	burg		Montg	omery
	Funeral		5. Social Security Number	6. Sex 1 AM 2 ☐ F		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h 9	Birthplace (State or Foreign Country)
	Director		017-20-2047	1 (4M) 2 (1 F	78	Yrs.			Feb. 3		lassachusetts
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Mary	ō	Maryland Mont	gomery		larksbu					1 ☐ Yes 2 X No
	n the	lec	10e. Street and Number	gomery	1 0	Talksou	10f. Zip Code			10g. Citizen of Wh	at Country?
	th wit	a D	23110 Frederick	Road			20871			U.S.A.	
	filed within 72 hours after death with the Maryland Hygiene. Ither then "naturel", or items 23s or 28s-f show ant, the Madical Examinar must be notified.	Funeral Director	11. Marital Status		ecedent Ever in Forces?	U.S. 13. V	Vas Decedent of H	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
0	or it	by Fu	1 Never Married 2 Marri	ed 1X Yes	2 □ No Give	_   .	☐Yes 2X No	Specify:	,,		White
Ś	tural tural	D D	3 Widowed 4 Divorced		Dates: WWI	1			1		
	In 72	Completed	(Specify only highes	t grade completed	·	(Give	lent's Usual Occup kind of work done OO NOT use retire:	during most of wo	rking	16b. Kind of Busin	iess/industry
7	d with	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Rep	airman			Applia	nce
3	S should be filed within and Menial Hygiene. Is marked other than "s aumatic evant, the Mar	Bec	17. Father's Name (First, Middle,	.ast)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	1100
<u> </u>	Menti Menti arked atic e	2	Joseph Francis	Stone				Annie G	. Crane		
	2 sho		19a. Informant's Name/Relationsh							er, City or Town, Sta	
ב ע	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentail Hygiene.  [Ham 27 is marked other than "natural", or items 23s or 28s-f show tother traumatic event, the Madical Examinar must be notified at		Francisca Stone	/ Wife	20h	23110 Place of Dispo	Frederic	ck Road,			land 20871
5	Pages nent of h nnt: If its ury or of		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation		m State	cemetery, cren	natory or other place	· 1	Date	20c. Location - Ci	y or Town, State
			4 □Donation 5 □Other (S)  21. Signature of Funeral Service I		Pi		e Cemeter			Mount Ai	ry, Maryland
0	permit. Depertrimports Imports any inju		Manthar	) 4m (	Nopp	M	oleswort	n-Williar	ns P.A.,	Funeral	Home
			23a. Part1. Enter the disease, or	complications that	caus the e	ath. Do not ente	or the mode of dying	ge Koad,	Damascus c or respiratory ari	s, Maryla	Approximate
	Physician		Immediate Cause (Final	one cause on	each line.	0	o n vanen				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Dee to	o (or as a conse		m Ces				
	Examiner		Sequentially list conditions	b. —		16.					
	D #	lner.	Sequentially list conditions, if any leading 1. immediate cause. Enter Underlying	Due to	o (or as a cons	iquende of):					
	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due t	o (or as a conse	ouence of):				<u> </u>	
ָבָּ פ	ficate be executed physicien and s the burial-transit	a			0 (0. 00 0 00.00	14001100 017.					
0	ficate physical stre	edical	£	d							
5	anding use	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c	utcome of preg	nancy				23d. Date of	f delivery
	deat	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Fe gnant at time of		Ectopic pregnancy Other (specify)	<u>'</u>		Month	Day Year
ָ ֡	at the	Ph.	9 □ Unknown						7		
<u>r</u>	w requires that the death certific been signed by the ettending p should be detached for use as	Ď	Part II. Other significant conditio	ns contributing to			iderlying cause giv	en in Part I.		_	ite to the cause of death?
5	need hould	eted		7	0000				1 4	′es 2 □ No 3 [	Probably 4 Unknown
	hest hest je 2 s	ompleted							24a. Was a autop	SV Drio	e autopsy lindings available to completion of cause of
5	sician: The le certificete he irector, page 2	O	25.14							2 No 1□	Yes 2 No
5	s certi	o Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	750/0	2 DOA Oth	05	ath Check only or		
5 1	ding Physician: h. After this certific funeral director,	$\vdash$	27. Manner of Death	28a. Dat	e of Injury	28b. Time of	28c. Injur	y at		lence 6 Other of the followinjury occurred	Specify)
5	tlendin death. tor: Aft the fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	,	onth, Day Year)	Injury	M 1 🗆	k? Yes 2∐No			
2	ir Attu	ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Flat	ce of Injury - At ding, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number (	or Rural Route Number,
ָׁ	oital o urs ef rai D	O									
:	To the Hospital or Attending Physician: The lew requires that the death certification 24 hours effer described within 24 hours effer described the confliction of the European Director: Affer this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying (Check only one)	xaminer: On the	he best of my kr basis of examir inner stated.	nowledge, death nation and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	e, and due to the curred at the time, d	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed (A	fonth, Day, Year)
			the	20	/	ILLI	DOE	358	57	01-	05-2014
++	AVI.		30. Name and address of person v	who completed car	use of death (Ite	em 23a) (Type, I	Print)		A 1.	200	
, ,	Sta	to.	31. Date filed (Month, Day, Year)	Lowiec 32.	Registrar's Sing	ature	recleri-	ek Ave	Gaith	eisbry i	10 20877
	Registr		JAN 0 5	2007	Believ.	15 Ap	ark				Month, Day, Year) ()5-2017 ()0 20877

			ricase	State of Ma							•	_	ie.	
		•	1 - For State Registrar	State of Ma	iylallu /	-	rtificate			uru we		ZUU	7	01203
			Decedent's Name (First, Middle, Last)	)			imoute	, 0, 0	Julin	2	Date of Death	g. No.		3. Time of Death
	Physicia /Medic		William St	auffer							Month January		Year 7	4:25 A M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, 7	Town, or I	ocation of			4c. County of		1.5
	, jê	y A	Glade Valley Nu						svill			Fred	ericl	ζ
	Funeral Director		5. Social Security Number 6. Se 217-09-7495	x 7. Age ]M 2□F	(In yrs. last b	Yrs.	If Under	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,			ace (State or Foreign
1000	r day		Usual Residence of Decedent	`							ct. 2,	1918	Mary	land
	arylan ahow	_	10a. State 10b. County		10c. City, To								10	d. Inside City Limits
	Ba-f a	Director	Maryland Frederi	ck		Walk	ersvi							1 XYes 2 No
	with t		10e. Street and Number 8789 Hickory Hill				10f. Zip (	Code	217	793	10	g. Citizen of Wh United		
	filed within 72 hours after death with the Maryland Hyghene. other than "natural", or Items 23a or 28s-f show ent, the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. 1	Was Decede	ent of His	panic Orig	gin? (Specif	y Yes or No-	14. Race		
စ္	or ite	Fur	1 Never Married 2 Married	Armed Forces?  1 X Yes 2 No			fYes, speci 1 ☐ Yes 2		, Mexican, Specify:	, Puerto Rio	an, etc.)		White, e	
993	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1945							Specify:	Whi	Lte
15-	n 72 i	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16	(Give	dent's Usual kind of worl DO NOT use	k done du	ion iring most	of working	1	6b. Kind of Bus	iness/Indu	ustry
212	iene.	ошь	Elementary/Secondary (0-12)	College (1-4or 5-	A.		ntant					Fina	ances	3
פַ	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)		1							aiden Sumame,	)	
ylaı	Ments Ments arked	ToE	Ralph W. St	auffer					Oda	Zimme	rman			
Maryland 21215-0036	2 sho and 1s m		19a. Informant's Name/Relationship (7)		19							City or Town, S		
	is 1 and 2 of Health as liem 27 is other trac		Katharine Stauff 20a. Method of Disposition	er / Wife	20b. Place				Hill	L, Wal		lle, MD Oc. Location - C		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Brootentt: If them 27 is marked other than "natural; or items 23a or 28a-f ahow eny injury or other traumatic event, the Medical Examinat must be notified at ODGs.		1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemet	ery, crer	natory or other	her place	$\mathbf{r}\mathbf{y} \mid 1$	1/8/20	_			Maryland
alti-	nit. Partme		21. Signatur, of Funeral Service Licens				2. Name and			y St	auffer	Funera	1 Hon	ne
m	Depa Impo eny li		1 ourther	Staul	m-		1621	Оро	ssumt			ederick		
*1	<i>p</i>		23a Part1. Enter the disease or comp shock, or heart failure. List only o	ications that caused ne cause on each line	the death. Do	not ent	er the mode	of dying	, such as o	cardiac or re	espiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	go	tec.	57		000						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	9 of):								
*		er	Sequentially list conditions,	b. Eve to for an a	nonsecuenn	a of):								
	ate be executed nysician and he burial-transit	Examiner	Sequentially list conditions, it any, leading to innitiodate cause. Enter Underlying Cause (Disease or injury that initiated events											
oʻ	be executed ician and burial-transit		resulting in death) Last	Due to (or as a	consequence	e of):							-	
8760,	ate be hysici the bu	lical		d										
x 68	The law requires that the death certificat te has been signed by the attending phyage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome o	of prognancy	_						12	- "	
Вох	atten Ifor u	clan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at 1	2 Fetal dea		Ectopic pre					23d. Date Mont		y Day Year
P.O.	the d by the ached	lsku	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	o or south		2 01/10/ (300	, c., y ,						
	s that gned b	y Pi	Part II. Other significant conditions co	ntributing to death bu	t not resulting	in the u	nderlying ca	iuse giver	n in Part I.		23e. Did toba	acco use contrib	oute to the	cause of death?
ord	equire en sig	ted	Congestive he	art ga	elur	·	sec	ent		<del>_</del>	1 🗆 Yes	25 ANO 3	Proba	bly 4 □Unknown
Records,	law i las be	nple	Myo cardial	shifar	ction	1	Par	ben	son	Ó	24a. Was an autopsy		ere autop	sy findings available pletion of cause of
E H			Lisease			10					perform 1 □ Yes 2		ath? ]Yes 2	2 □ No
Vital		9 Be	25. Was case referred to medical examiner?	Hospital:				Other	- /	-	check only one			
	y Phys ar this eral di	n; To	1 Yes 75 No	28a. Date of Injur	y 28b	. Time of		A Bc. Injury Work	ANUT			ce 6 Other		1
Ö	ttending death. stor: Afte the fun	atlo	Accident 5 ☐ Pending investigation	(Month, Day	Year)	Injury	М		? es 2□N	No				
Division of	Lor Atte after de Directo In by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, (Specify)	farm, str	eet, factory,	office		28f	Location (Stre	et and Number State)	or Rural	Route Number,
	Hospital or Attending 24 hours after death. Funeral Effrector: After tely filled in by the fune		A A				ran and an entire land	********	- Proposition Control					
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Elirector: After completely filled in by the funer	Medical	29a. Certifier (Check only 2 Medical Examinate)	ner: On the basis of and manner stal	examination a	ind/or in	vestigation,	in my opi	nion, deat	diplans, and thioccurred	at the time, da	te and place, an	ner as sta id due to t	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	/7/			29c.	License	number		29	d. Date signed	(Month, D	Pay, Year)
	NA.		14/2/1	Thank	The I	220)	1	D = 3	351	83		Museu	4,	2007
-	THE ALL		of prison who c	leted cause of de	ath (Item 23a	) (Type,	Print)	-	1 -1		2	4	11,	100
	10		31. Date filed (Month, Day, Year)	7E/1 32. Paistra	300)	U	125t	911	STO	reet	10	oder.	ick	1 11)
The state of the s	Sta Registr			007 Section	r's Signature	A	barte							

		1 - For Stata Registrar			epartment of Certificate of		F	lag. No.	007	01204
Physic /Med		Decedent's Name (First, Middle, Lase     ETHEL MARIE SNIDE)	R				2. Date of Dea Month JANUARY	2,	Year <b>2007</b>	3. Time of Death 3:40A M
Exami Funeral Director	P	232-68-8233	CAL CENTER	e (In yrs. last birtho	ANNAPOL	r If Under 24 Hrs.		ANNE		EL lace (State or Foreign try) VIRGINIA
Marylend a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD PRINCE G	EORGES	10c. City, Town of	or Location					0d. finside City Limits 1 ☐ Yes 2 🗶 No
th with the 23a or 28	al Director	10e. Street and Number  14997 HEALTH CENT	ER DRIVE A	PT 201	10f. Zip Code <b>20716</b>			USA	of What Coun	try?
ING Z I Z I 3-UU30  be filed within 72 hours after death with the Marylend tlai Hygiene. Indicate then "naturet", or theme 23a or 28a-f show event, the Medical Exertine roust be notilised at	d by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🏋 If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🟋 N		pecify Yes or No- o Rican, etc.)		Race - America Black, White, a cify: WHTT	etc.
Maryland 21215-0035 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other then "naturet", or treumatic event, the Medical Exem-	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12) 12	de completed) Cotlege (1-4or 5	+)	ecedent's Usual Occ Give kind of work don fe. DO NOT use retii	e during most of wor	rking		Business/Ind	lustry
aryiand should be file nd Mental Hy marked oth martic svent	To Be (	17. Father's Name (First, Middle, Last) HAGAN HARDING SMI*				18. Mother's Nar	ne (First, Middle, GINIA AD		ame)	
		19a. Informant's Name/Relationship ( JEFFREY ALLEN SNI)			lailing Address (Street) 6 ELLICOT					
allimore, mit. Pages 1 er partment of Hea portant: if Item y injury or otherca.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other particle)  MEMORIAL	JANU.	ARY 4,	20c. Locatio	n - City or Tov	wn, State
Dallimo permit. Page Department important: if eny injury or		21. Signature of Fundal Service Licer	\$00		22. Name and Add FELLOWS, I 106 SHAMR(	HELFENBEIN	, AND NE CHESTER,	WNAM 1 MD 21	FUNERAI 1619	HOME, P.A
be four, ificate be executed ificate be executed by physicien and as the burial-transit as the burial-transit.	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only timmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a c.	a consequence of)				531,		Approximate Interval Between Onset and Death
death cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 □ Fetal death	3 ☐Ectopic pregnan 5 ☐ Other (specify)	су			Date of deliver Month I	ry Day Year
T at d	þ	Part II. Other significant conditions o	ontributing to death bu	ut not resulting in th	e underlying cause g	iven in Part I.		bacco use co		e cause of death?
	Completed						24a. Was a autops perform	ned?	b. Were autop prior to com death? 1 \( \text{Yes} \) 2	sy findings available inpletion of cause of
	To Be	25. Was case referred to medical examiner? 1  Yes 2 No	Hospital: 1/2Jnpatie	nt 2 ER/Outpa	atient 3 DOA		ome 5 Reside	-	Other (Specify,	)
e je	Certification:	27. Manner of Death  1			ry W M 1[	uryat ork? ]Yes 2 ∏No	28d. Describe he	ow injury occ	urred	
		4 Homicide determined	building, etc	: (Specify)	, street, factory, office		28f. Location (Si City or Town	n, State)		
To the Hospital c within 24 hours ef To the Funeral D completely filled is	Medical	one) 2 Medical Exam	ysicien: To the best of iner: On the basis of and manner sta	examination and/o	r investigation, in my	opinion, death occu	rred at the time, d	ate and plac	e, and due to	the cause(s)
To To		29b. Signature and title of certifier			DO	SCLS &		J.ANJA	ned (Month, D	207
		30. Name and address of person who	completed cause of de	Path (Item 23a) (Ty	po, Print) Michical	Perok way	· Animal	0-11	N.S	2140,
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Coarle					

			1 - For State Registrar	State of Maryland		artment of rtificate of			giene Reg. No.200	 7 01205
f	Physici	an	1. Decedent's Name (First, Middle, Last) Hannah Shama					2. Date of De Month	Day Ye	- 11
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of	Death	4c. County of D	eath
	Funeral Director		5. Social Security Number 6. Sev 900-26-4449	Medical Ce. 7. Age (In yrs. II) 1 46	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir Min. (Month, Da Mar. 22	WiCh th gy, Year) 9. 2, 1960 J	Birthplace (State or Foreign Country) ordan
	deeth with the Maryland ms 23a or 28e-f ehow Frivat be tidtiffed at	tor	10a. State 10b. County MD Worches		, Town or Lo	Ocean C	ity			10d. Inside City Limits 1X☐ Yes 2☐ No
	th with the 23a or 28o	Funeral Director	10e. Street and Number 12648 Whisper	Ггасе		10f. Zip Code	1842		10g. Citizen of What Jordan	Country?
	ors after dee	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13.	Was Decedent of If Yes, specify Cul		in? (Specify Yes or No Puerto Rican, etc.)		merican Indian, /hite, etc. ddle Eastern
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Marylan Health and Mental Hygiene. I the little and 78 or 28e-f show flem 21 is marked other than "naturel", or flems 23a or 28e-f show other traumatic event, the Madical Exertiner must be inclified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11 (Grad.)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire emaker	ipation during most ed)	of working	16b. Kind of Busine	
yland	should be filed and Mental Hyg marked othal umatic event, I	To Be C	17. Father's Name (First, Middle, Last)  Dahod Hason	·				r's Name (First, Middle ab Mohmad		
, mar	and 2 shore		19a. Informant's Name/Relationship (Ty Sal Ramadan/Son-	-in-law	1264	48 Whispe		r or Aural Aoute Numb ce, Ocean C	ity, MD 21	1842
Baltimore	permit. Peges 1 at Department of Hea Important: If Item eny Injury or othe		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Removal from State Muha	ammed	osition (Name of matory or other pla Bukas Ce	m. O	1/04/07		urg, Maryland
Dall Dall	Departition Departition of the portion of the portion of the properties of the prope		21. Signature of Funeral Service License	askow	21	2. Name and Addr 6 N. Mai	ess of Facility	Framptom F Federalsb	uneral Hom urg, MD 21	e, P.A. 632
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.  METASTATION  Due to (or as a consequ	B	ter the mode of dy	-	Cardiac or respiratory a	errest,	Approximate Interval Between Onset and Death
'n	ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence)						
08/PU	ficate be physicie as the bu	edical	٠,	d						
C. Box	at the death certificate by the ettending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregpant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3[	□Ectopic pregnand □ Other (specify)	су		23d. Date of Month	delivery Day Year
cords, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	Λ	olting in the $DEN7$		ven in Part I.		tobacco use contribut	e to the cause of death?  Probably 4 Unknown
Ä	The horage	Completed	PLEURAL	EFFUSION				24a. Was auto perfo	psy prior ormed2 death	
VItal	iding Physician: th. : After this certifica funeral director, is	Be	25. Was case referred to medical examiner?	to anitati				of Death (Check only		
ō	ral car	. To	1 Yes 2 No	lospital: 1 Inpatient 2   8	28b. Time o	30 004		sing Home 5 Resi	dence 6 Other (5	Specify)
0	Attending r death. actor: After oy the fune	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	W	ork? ]Yes 2∐N		now inquiry occurred	
DIVISION	al or Atte s after des al Directo ad in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location ( City or To	Street and Number of wn, State)	r Rural Route Number,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	th occurred at the investigation, in my	time, date and opinion, deat	I place, and due to the h occurred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
)	To t To t	W	29b. Signature and title of certifier	W.T	UD	29c. Licer	se number	5/5	29d. Date signed (M	onth, Day, Year)
			30. Name and address of person who co	ompleted cause of death (Item			SPORE	E DK SA	ALISBURY	MD 21804
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat		laced 1				

DHMH 17 Rev 1/2001

		4 27	tment of Health and Mental H	ygiene 007 01206
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last)  Ardein Varden Selle  4a. Facility Name (If not institution, give street and number)	2. Date of Month SAN.  4b. City, Town, or Location of Death	
Funeral Director	A.	212-14-7931 1 M 2 F 85 Yrs.	Hagerstown, Md  If Under 1 Year If Under 24 Hrs. 8. Date of It  Months Days Hours Min. 1-5	Birth Day, Year)  - 2/ Pennsylvania
72 hours after death with the Maryland naturel; or Items 23s or 28s-1 show deal Examiner must be notified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca  Maryland Washington Hagersto  10e. Street and Number	WN 10f. Zip Code	10d. Inside City Limits 11 Yes 2 □ No  10g. Citizen of What Country?
be filed within 72 hours after death with the Marylan hal Hygiene. Identifies then "naturel", or iteme 23e or 28a-f show event, the Madical Examiner must be notified at	b	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Swindowed 4 Divorced Year or Dates:	21740 as Decedent of Hispanic Origin? (Specify Yes or less, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2X No Specify:	Specify: white
filed within 72 h Hygiene. other then "nate	e Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 9  17. Father's Name (First, Middle, Last)	nt's Usual Occupation nd of work done during most of working D NOT use retired)  ET  18. Mother's Name (First, Midd	16b. Kind of Business/Industry  leather mfg.
Maryian of 2 should be lih and Mental 27 le marked o treumatic eve	To Be	John Edward Starliper  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Lottie Willar Address (Street and 403023 & FRogress NR OX 367, Cascade Md. 21	d Hornbaker der, City or Town, State, Zip Code)
Detitiniore, Inveryita permit. Pages 1 and 2 should Department of Heelih and Mar Important: if item 27 is marke any nighty or other treumsitic single.		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposit cemetery, crema Rose H111	ion (Name of Date fory or other place)  Cemetery 1/4/07	20c. Location · City or Town, State Hagerstown, Maryland FUNERAL HOME
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that carsed the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or sa consequence of the conditions).	15 E. Wilson Blvd., Hag	gerstown, Md. 21740
of oU, rate be executed hysicien and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
wrequires that the death certifical been signed by the attending pt should be detached for use as it	Physician/Med		ctopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
13 8 8 61	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the under the supplied of the	(Bullelion 15	topsy prior to completion of cause of
Physicien: rthis certificaral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 (2 Ho Hospital: 1 Inpatient 2 ER/Outpatient 2 Rough Input (Month, Day Year)  1 Teatural 5 Pending (Month, Day Year)	26. Place of Death	The state of the s
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After compietely filled in by the fune	Certification;	1	Work? M 1 Yes 2 No	(Street and Number or Rural Route Number, rown, State)
To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai	29a. Certifier  (Check only one)  2   Madical Examiner: On the basis of examination and/or investant and manner stated.	occurred at the time, date and place, and due to the stigation, in my opinion, death occurred at the time.  29c. License number	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
ンH-フ St Regist	ate	30. Name and address of person who completed cause of death (Item 23a) (Type/Pr 31. Date filed (Month, Day, Yeak)  32. Registrar's Signature	115665> Frise 200 Hage	1170-2;2007 ultrun mo 21740
DHMH 17 Rev 1/		JAN 0 5 2007 Been D. Spe	All I	

			For State Registrar	State of Ma	ryland / Der Ce	partment ertificate			nd Me		giene 0 0	7 01207
1	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Dea	Day	3. Time of Death 5:54 a M
	/Medic		Donald Lee Theu:  4a. Facility Name (If not institution, give sti			4b. City, 1	Town, or I	ocation of	Death	Jan.	1, 2007	
	Examili	ei S	1801 Brickhouse	_				kirk			Ca	lvert
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda		1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birti (Month, Da)	h 9. V, Year)	Birthplace (State or Foreign Country)
u.C	Director		578-42-2670 Usual Residence of Decedent		13					2/6/1	933	DC
	death with the Maryland ima 23a or 28a-f ehow ir must be notified at	2	10a. State 10b. County		10c. City, Town or							10d. Inside City Limits 1127 Yes 2 ☐ No
	28a-f	Director	MD Calve	ct		10f. Zip		kirk			10g. Citizen of Wha	
	h with	ie O	1801 Brickhouse	Poad			207	754			USA	
	r deat	Funeral	11. Marital Status	. Was Decedent E Armed Forces?	ver in U.S.	3. Was Deced			in? (Spec	cify Yes or No- Rican, etc.)		American Indian, White, etc.
36	be filed within 72 hours after death with the Marylan ital Hyglene. ad other than "natural; or itema 23a or 28a-f show event, it a Medical Examinat must be notified at	by Fi	1 ☐ Never Married ② Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates: 1	1	1 ☐ Yes 2	X No	Specify:			Specify:	White
Maryland 21215-0036	72 hou	eted	15. Decedent's Educa (Specify only highest grade	tion	16a. Dec	cedent's Usua ve kind of wor	Occupat	tion urina most	of workin	la l	16b. Kind of Busin	
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life	. DO NOT us	e retired)				Police	Department
d 2	e filed within al Hygiene. other than vent, ir e Me	Be Co	12 17. Father's Name (First, Middle, Last)		Pro	perty	_				Maiden Surname)	Depar ement
/lan	should be and Mental marked o umatic eve	To B	Edward Arthur T	neurer				Hele	en M	Marie	Bergling	9
Man	and and is m		19a. Informant's Name/Relationship (Type			_					er, City or Town, Sta	ite, Zip Code)
e,	s 1 and if Health item 27 other tr	0	Betty Theurer/W: 20a. Method of Disposition	ife	20b. Place of Dis	Box 5	ne of			ate MD	20754 20c. Location - Cit	y or Town, State
E O	# D - L	li	1 N Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	So. Me	rematory or of moria		1	/5/	2007	Dunkirk	, MD
Baltimore,	permit. Page Depertment of Important: if any Injury or once.		21. Signature of Funeral Service Licenses	0		22. Name an	d Addres	s of Facility	Ra	ymond-	-Wood F.	H., P.A.
	g ⊽ ≅ 9 9		23a. Part1. Enter the disease, or complic	C .							MD 20754	Approximate
	Dhamisis		shock, or heart failure. List only one	cause on each lin	Θ.			_			1651,	Interval Between Quiset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	consequence of):	hen	7-1	for	W	~		19cm
	Examiner		Sequentially list conditions, b.	Coro	consequence of):	rtero	10	isea	se	Ł		Zyears
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):	Ć	)					,
oʻ	be executed ician and burial-transit		that initiated events c. resulting in death) Last	Due to (or as a	a consequence of):							
8760,	ate hys	edicai	d.					-				
9 x	death certifics e attending ph id for use as t		IF FEMALE:	c. If yes, outcome	of pregnancy						23d. Date of	of delivery
. Box	death e atten d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death	3 □Ectopic pre 5 □ Other <i>(sp</i> e					Month	
P.0		Physician/M	9 Unknown	9□ Unknown								
ds,	The law requires that the Ite has been signed by th bage 2 should be detache	by	Part II. Other significant conditions cont	nbuting to death bu	It not resulting in the	a underlying ca	ause give	n in Part I.				ite to the cause of death?  ☐ Probably 4 ☐ Unknown
CO	w require s been si should I	lete	Chan where	112	2100	An ara	da	5,00	Se.	24a. Was	an 24b. We	re autopsy findings available
Vital Records,	The lay ate has page 2	Completed	crostate car	COPILL	Jean	01010				autop perfo 1 ☐ Yes	rmed? dea	r to completion of cause of th? Yes 212 No
/ita	Phyelcian: The this certificate hiral director, page	Be	2 as case referred o medical	espital:			100		of Death	(Check only o		
ō	Phys this al di	To To	1 Yes 2 No	1 🔲 Inpatie	nt 2 ER/Outpa			4 1401			dence 6 Other	
ion	Attending I ir death. ector: After by the funer	atior	1 ✓ Natural 5 ☐ Pending investigation	28a. Date of Injur (Month, Day	<i>i</i> Ye <i>ar)</i> Injur	У	8c. Injury Work 1 🗆 Y	? ′es 2 □ N	No			
Division	or Attender de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farm, c. (Specify)	street, factory	, office		2	28f. Location (3 City or Tox		or Rural Route Number,
	Hospital		29a. Certifier 1 Certifying Physi	cien: To the best	of my knowledge, de	eath occurred	at the tim	e date and	d place, a	and due to the	cause(s) and mann	er as stated
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Examin	er: On the basis of and manner sta	examination and/or	r investigation,	, in my op	inion, deat	th occurre	ed at the time,	date and place, and	due to the cause(s)
	To the vithin 2 To the comple	Σ	29b Signature and title of certifier	)			License	number 3			29d. Date signed (	Month, Day, Year)
			30 Name and address of	aploted as in it	me me		<b>→</b>	لاد،			1/21	0)
	10		30. Name and address of person who cor	MD. 11	The second second	oe, Print) WN (	ente	er Bli	Vol S	vite 2	03 Dunk	IVK MD 20754
4	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registr	s Signature		. P. a					
18.5	negisi	rar	6 H MAL.	ZUUT P P	R-09.10 0 KI	· ANDER						

			For State (		artment of Health and I rtificate of Death		iene 2 0 0 7	01208
	9.4	3	Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
4	Physici		Dorothy Bailey Tl	nawley		JAN.	05, 2007	8:30 рм
1 A	/Medic Examin	5.0	4a. Facility Name (If not institution, give street and no	ımber)	4b. City, Town, or Location of Death	1	4c. County of Death	
-			Caroline Nursing Ho	ome	Denton		Carolin	e
41	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Apr. 20,	Year) 9. Birthp	lace (State or Foreign try)
3	Director		215-01-1164 1 M 2 TF	91 Yrs.	William Days	Apr. 20,	1915   Mary	
	pu 🔹		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	sho	٦	MD Caroline		ton			1 ves 2 □ No
	the A	Director	10e. Street and Number	Den	10f. Zip Code	10	og. Citizen of What Cour	atov?
	with a or		520 Kerr Avenue		21629		nited Sta	,
	ns 23	Funeral		cedent Ever in U.S. 13.			14. Race - Americ	
<b>'</b>	r then	F	1 Never Married 2 Married 1 Yes	2 🔂 No	Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	
ဗ္ဗ	urs a	by	3√√Widowed 4 Divorced If Yes, G Year or	ive	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	ite
ည	within 72 hours after death with the Maryland ene. Than "natural", or items 28a or 28a-i show he Maylical Examine rount be notified at	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occupation	rkina 1	16b. Kind of Business/Inc	dustry
7	ithin	nple		(1-40r5±)	kind of work done during most of wor DO NOT use retired)		'urniture	Ctoro
7	ygier yertt	S	11 (Grad.)	рос	okkeeper			Store
ב	tal H d oth	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, M		
<u>\S</u>	Men	2	Willie Bailey		Gerti			
Maryland 21215-0036	12 sh n and r is n		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Au			
e)	1 and Healt em 2 ther t		H. Wilson Meredith/Neph	20b. Place of Dispo	Houston Branch Resistion (Name of		Calsburg, MI	
ية	ages nt of I :: If it		13☐ Burial 2 ☐ Cremation 3 ☐ Removal from	cemetery, cre	matory or other place)	68		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner rule be notified at ance.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		- 1		ederalsburg	
Ba	Depa Impo any ii		Michael 7- Est	en 2	2. Name and Address of Facility Fr 16 N. Main St., F	amptom Fi ederalsb	uneral Home urg, MD 216.	, P.A. 32
A	Physician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	caused the death. Do not en each line.	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between onset and Death
	/Medical Examiner		resulting in death)  Due to	(or as a consequence of):	101101010	N -		
2	- LXaIIIIIIEI	L	Sequentially list conditions, b.	rovar	y thrueity	Disc	ease 1	10als
	ed sit	Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):	,			
	icate be executed physician and s the burial-transit	xar	that initiated events c c Due to	(or as a consequence of):				
8760,	siciar siciar s buri	Sal	l d					
68	ificati g phy as the	edic	<u> </u>					
Вох	that the death certific ed by the attending p detached for use as	Physician/Medical		utcome of pregnancy	7		23d. Date of delive	ery
	deatl e atte	lcia	1 Ves 2 DNo 4 Pred	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
0	at the by th	hys	9 ☐ Unknown 9☐ Unk	nown				
	88 G 90	by	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I.		acco use contribute to the	
b	w requir been si should	ted	Cerebiones	scriai c	accide Nu	1 🗆 Ye	is 2 €No 3 ☐ Prob	ably 4 Unknown
ecc	e lawr has be je 2 sh	Completed	Diabetes	Mellit	<u>US</u>	24a. Was ar	y prior to coi	psy findings available mpletion of cause of
~	The ate h page	9				perform 1 ☐ Yes &	ned? death? □No 1□Yes	
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			ith (Check only one	9)	
of Vital Records,	Physi this c al dire	2		Inpatient 2 ER/Outpatie			nce 6 Other (Specifi	y)
Ĕ	ding F h. Alter funer	lon	1 Natural 5 ☐ Pending (Mo	of Injury 28b. Time of Injury Injury	Work?	28d. Describe ho	w injury occurred	
isi	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be 289 Place	ee of Injury - At home, farm, st	M 1 Yes 2 No	28f Location (Str	reet and Number or Rura	I Route Number
Division	iel or Attendest s after death al Director: ad in by the	Certification:	4 Homicide determined 286. Flat buil	ding, etc. (Specify)	root, ractory, office	City or Town		7,00,07,00,,
	To the Hospitel or Attending Physicien: The la virthin 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (	(Check only 2 Madical Examiner: On the	ne best of my knowledge, deat basis of examination and/or in nner stated.	th occurred at the time, date and place evestigation, in my opinion, death occurrence.	e, and due to the ca erred at the time, da	use(s) and manner as state and place, and due to	tated. the cause(s)
	To the	Me	29b. Signature and title of certifier	-	29c. License number	29	9d. Date signed (Month,	Day, Year)
			1 James Sex	pr M	D3137	6	1-7-07	7
			30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print)	00 >		. 0
_			James Siste	35 920	Market"	SC D	euto	U MS-
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	askis			

DRMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Nancy Tomson lanuary 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Caroline Nursing Home, Denton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. McLy 22, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□ F 78 **Director** 136-24-3161 Jersey New Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at aging. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Preston Maryland Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21655 United States of America 23278 Holly Park Drive Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced Caucasian Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Library 12 Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Peckham Scott Edward Duncan Norton-Taylor 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23278 Holly Park Drive, Preston, Maryland 21655 Robert S. Tomson Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2007 Dover, Delaware 4 Donation Capitol Crematory 22. Name and Address of Facility P.A. Poore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CUMAN disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten edetached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☐ No 2 Norsing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After t 1 Matural
2 Accident Injury 5 Pending 1 Tyes 2 □ No neral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Direct Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 9 Registrar

		•	For State Registrar	State of Ma	ıryland			t of H		ind Me		giene Rag. No.	007	01210	J
	A.		1. Decedent's Name (First, Middle, L	ast)						2.	Date of Dea	ath Day	Year	3. Time of Death	1
	Physicia /Medic		Freda W	ilson							Januar	y 3	, 200		М
	Examin	_	4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of	f Death		4c.	County of Dea	th	
		1	Glade Valley N		(In ore In	nt histoday)		alker	svil		Date of Birt	h	Frede	rick thplace (State or Fore	vide
	Funeral Director		5. Social Security Number 6. 214-07-1845	4 T 14 ME 16	e (In yrs. Ia. 14	Yrs.	Months		Hours	Min.	(Month, Da	y, Year)	1913 F	Pennsylvan:	ia
			Usual Residence of Decedent		•							_ ,			
	how		10a. State 10b. County Maryland Frederi	015		Town or Lo		Δ.						10d. Inside City Lim	
	Be-f s	cto		CK	VV C									1 <b>X</b> Yes 2	140
	th with th	Funeral Director	10e. Street and Number 56 W. Frederick	Street				1793				US. Citi	zen of What Co A	ountry?	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or terms 23s or 28s-f show shent, the Madical Exertains must be natified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Dece f Yes, spe 1 ☐ Yes	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No can, etc.)		14. Race - Ame Black, Whi Specify: V		
Ş	72 hor	ted	15. Decedent's (Specify only highest g	Education		16a. Dece	dent's Usu	al Occupa	tion	of working		16b. Ki	nd of Business	/industry	
7	c • a	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT L	se retired)	dring most	or norking		Dama	t t	atoro	
	filed wi Hygien other th	Completed	12			Retai	LI sa	Les	40.44-15-	d- N //		-	rtment	store	
Maryland	should be filed within nd Mental Hygiene. Imarked other then ametic svent, the Manatic sv	To Be	17. Father's Name (First, Middle, La: Charles Sisle:								First, Middle, Lowery		Sumame)		
	nd 2 ilth ar 27 is r trsu		19a. Informant's Name/Relationship Kenneth Wilson –			19b. Mailir 4915 N	ng Addres Maria	nne I	nd Numbe Orive	, Mt.	Route Numbe Airy,	er, City o Mar	yland	Zip Code) 21771	
Baltimore,	0 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Cei	ace of Dispo metery, crer y Gap	natory or	other place		Dat   20–9–			stone,	Town, State Maryland	
Balt	permit. Pag Department Important: any injury o		21. Signaluse of Funeral Service Lig	Ansee -	My				s of Facility	Stai			ral Hor	ne ryland 217	02
1			23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused	the death.			•						Approximate	
3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	JE.	My	vco	M	el	fol	out	rn		Interval Between Onset and Death	/
3760,	ate be executed hysicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as d.		,	oti	L (	ord	lion	seul	Lour	dise	year	
O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic p						23d. Date of de Month	livery Day Year	
ds, P	8 5 8	by	Part II. Other significant conditions	11 2	ut not resul	lting in the u	nderlying	cause give	on in Part I.			obacco u Yes 2,	_	o the cause of death?	
Records,	te law require has been signe 2 should b	Completed	8								24a. Was autop		24b. Were a prior to death?	utopsy findings availa completion of cause	ible of
	ficete ficete or. pa		25. Was case referred to medical						00 Pl	-10	1 Yes	2/2 No	1 Te	s 2 No	
₹	s cert directi	o Be	examiner?	Hospital:	nt 2 P	R/Outpatier	nt 3 D	OA Othe			Check only o		6 □Other (Spe	acity)	
0	Phy er this	-	27. Manner of Death	28a. Date of Inju- (Month, Day		28b. Time o		28c. Injury Work			d. Describe			,,,,,	
0	ath. r: Aft	atio	1 Anatural 5 Pending 2 Accident investigat		y rear)	прогу	м		res 2 🗆 i	No					
Division of Vital	el or Atte efter de l Directo d in by th	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At hor c. (Specify)	me, farm, st	reet, facto	ry, office		28	f. Location ( City or To			lural Route Number,	
	To the Hospitel or Attending Physician: The lav within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best taminer: On the basis of and manner sta	fexaminati	vledge, deat ion and/or in	h occurred ivestigatio	at the tim	e, date and pinion, deat	d place, and th occurred	d due to the at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
)	To the within To the comp	Me	29b. Signature and title of certifier				29	c. License		516	-		e signed (Mon	th, Day, Year) 2007	)
	3		30 Name and address pure with	no completed cause of d	eath (Item	23а) (Туре.	Print)	7	A F		FRE		MD	1702	
	Sta Regist		31. Date filed (Month, Day, Year)	2007 32 tegistr	ar's Signat	7 4	redi	i j	1-)		,		, , ,		

Registrar

State

Registrar's Signature

DHMH 17 Rev 1/2001

			. For	State of Mary	land / Depa	artment of	Health and	Mental Hyg	iene	
		_	State Registrar		Ce	rtificate of	Death		eg. No.?	01213
	Physicia	an	1. Decedent's Name (First, Middle, Last) Scott Gordon Yutzy	,				2. Date of Deat Month January	Dav Year	3. Time of Death 9:40 AM
	/Medic Examin	al	4a. Fecility Name (If not institution, give s			4b. City, Town,	or Location of Dea		4c. County of Death	
	Examin	eı	Goodwill Mennonite			Grantsv			Garrett	
	Funeral		5. Social Security Number 6. Sex 172–12–0239	7. Age (li	n yrs. last birthday) 86 Yrs.	If Under 1 Yea Months Days		8. Date of Birth (Month Day, April 1	1,1920 Pen	nplace (State or Foreign Intry) nsylvania
	Director	-	Usuat Residence of Decedent					nprii -	2,1320 10.	
	arylan •how	7	10a. State 10b. County		Oc. City, Town or Le	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	289-f	Director	PA Somerse	) T	Springs	10f. Zip Code		1	0g. Citizen of What Co	untry?
	h with		176 King St.			1556	2		USA	
	r deat	Funerai		2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? ( ban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. Than "netural", or Items 23e or 28e-f ehow he Madical Ezamilier mast be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give WW Year or Dates:	-	1 ☐ Yes 2 <b>X</b> No	Specify:		Specify:	White
20	72 hou	eted	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occu	e during most of w	rorkina	16b. Kind of Business/	
7	within one. than	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life.	DO NOT use retir	ed)		II C Aven	W 2
Q	filed Hygie other if	Be Co	17. Father's Name (First, Middle, Last)		Cniei	warrant	Officer 18. Mother's N	ame (First, Middle, I	U.S. Arn Maiden Sumame)	ıy
/lan	Menta Menta Prked stic ev	To B	Samuel Yutzy				Eleano	r Baker		
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.  If Health and Mental Hygiene "netural", or Items 23a or 28e-f show them 21a marked other than "netural", or Items is another the notified at other treumatic event, the Moulcal Examinar hand be notified at		19a. Informant's Name/Relationship (Type Trudy Hutzel/Daught				stand Number or F		r, City or Town, State, Z 15558	ip Code)
ē,	tem 2	1 1	20a. Method of Disposition		20b. Place of Disp				20c. Location - City or	Fown, State
E O	Peges nent of nnt: If I		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Springs			5,2007	Springs, PA	1
Baltimore,	permit. Peges Department of I Important: If It eny Injury or o		21. Signature of Funeral Service License	е /		2. Name and Add			uneral Home	es, P.A.
	0 0 = 0	Н	23a. Part1. Enter the disease, or compli	actions that caused the				ntsville, ac or respiratory arr		Approximate
	Physician		shock, of heart failure. List only on transdiate Cause (Final					an Dise		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c	onsequence of):	Carlan	ovasem	ave DISC	saye.	ayears.
М	Examiner	-	Sequentially list conditions	Due to (or as a c	onsequence of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		5/10 <b>545</b> 6/10 <b>5</b> 6/7.					
ó	ate be executed hysicien and he burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
68760,	tificate being physical as the bu	dicai								
Box 6	certifi nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of p					23d. Date of deli	very
Ö.	The law requires thet the death certifical ate has been signed by the attending phypage 2 should be deteched for use as the	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		□Ectopic pregnan □ Other (specify)	cy		Month	Day Year
P.O.	het the id by th	Phy	9 ☐ Unknown  Part II. Other significant conditions con		of resulting in the	ınderiving cause d	uven in Part I	23e. Did tol	bacco use contribute to	the cause of death?
Vital Records,	uires the signed lid be del				,				es 2 No 3 Pr	
000	aw requir is been si 2 should I	piete						24a. Was a		topsy findings available
ž	ysician: The lavis certificate has director, page 2:	Completed	1					perform	med? death? 2⊠No 1 ☐ Yes	
Vita	sician: The certificate irector, pag	) Be	25. Was case referred to medical examiner?	ospital:	• E 50/0 · ·			eath (Check only on		
	Attending Physician: r death. sctor: After this certific by the funeral director,	n: To	1 Yes 25 No 27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatie	of 28c. In			ence 6 Other (Spec ow injury occurred	ary)
sior	endin eath. or: Aft	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day 1	oar) Injury		Yes 2 No			
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, si Specify)	reet, factory, offic	9	28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
_	To the Hospitel or Attending Phys within 24 hours effar death.  To the Funeral Director: After this completely filled in by the funeral of		29a. Certifier 1X Certifying Phys	sician: To the best of n	ny knowledge, dea	th occurred at the	time, date and pla	ce, and due to the c	ause(s) and manner as	stated.
	the Ho sin 24 the Fu apletel	ledicai	one)	and manner stated					ate and place, and due	
	Veith Con	Σ	29b. Signature and title of certifier  WWW.south	Elin	MD		05532		Jan 02	
		IA.	30. Name and address of person who co			. Print)				200 /
	441	Y Pr	wonsock shin	J MD 48	Town Te	mace	Frostbu	ng MD21	532	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Redistrar's	Signature	Annall o		-		

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month ILLIAN ALLERS 8:10 PM JANUARY 14 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2 F Months 220-05-9258 Sept. 27, 1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No Baltimore Maryland | Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3007 Pennsylvania Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Lvdia Cramer Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3638 Handel Ct., Pasadena, MD 21122 Jeanne Geisendaffer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/17/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licen 3620 Wilkens Ave., Baltimore, MD 21229 23a-Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mender Ineumonia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Heart 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hypertension Chronic obstructive pulmonary Disease 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Mann Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Show

"natural", or items 23a or 28a-f shovedical Examiner must be notified at

traumatic event, the Medical

Department of Health a Important: If Item 27 is any injury or other trainonce.

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

Pages 1

72 hours after

3altimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

the Hospital or Attending Physician:

hin 24 hours at

0

Medical

State

Director

Funeral

Completed by

Be

ဥ

Examine burial-transit Physician/Medical the as signed by i þ Completed certificate Be Certification: To this After Director: /

29a. Certifier

(Check only one)

1 Natural 5 ☐ Pending investigation 2 Accident 4 Homicide

6 Could not be

28a. Date of Injury (Month, Day Year)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 2 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

RESOOI

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH HANOVER ST, BALTIMORE, MD 21225 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

Registrar DHMH 17 Rev 1/2001

	-	For State Registrar	State of Marylan		partment of Fertificate of			giene Reg. No.		
Physicia		Decedent's Name (First, Middle, Last,     A	ANDERS	301	J		2. Date of De.		2007	3. Time of Death
/Medic Examin		4a. Facility Name (If not inditution, give Baltimore Washin		Cente	4b. City, Town, o	Burnie		Ar	ty of Death nne Art	
Funeral Director		032-26-84/4	7. Age (In yrs. I	ast birthda Yrs.	y) If Under 1 Year Months Days		Irs. 8. Date of Bird in. (Month, Da NOV 4,	y, Year)	9. Birthpla Counti	oce (State or Foreign y) Ohio
the Maryland 28a-f ehow notified at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Arur		y, Town or Ga	Location Imbrills					d. Inside City Limits 1 ☐ Yes 2 🛣 No
ath with the Maryla s 23a or 28a-1 ehor	Funeral Director	10e. Street and Number 977 Summer Hill			1	054	(Specific Ves or No		f What Count ted Sta ace - America	ates
hours after death with the Maryland ture!; or items 23a or 28a-f ehow al Examiner must be notified at	Ď	11. Marital Status  1 Never Married 2 Married  3 MWidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	.5.	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Specify:	uerto Rican, etc.)	Spec	ack, White, e	
vithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retire ceeper/Und	during most of d)			Business/Indi	ustry dential
d be filed v ental Hygie ced other t	Be	12th  17. Father's Name (First, Middle, Last)  Walter	Ayres	DOOK	ceeper/ond		Name (First, Middle	, Maiden Suma		
permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than 'natur eny injury or other traumatic event, the Medical Once.	٦°	19a. Informant's Name/Relationship (T) Judy Anderson Bruk	ype, Print)		ailing Address (Street	and Number of	Rural Route Numb Windsor	Mill,	Mary1a	nd 21244
Pages 1 ament of He ment: if item lury or othe		20a. Method of Disposition  1	Removal from State Ar1	emetery, c	sposition (Name of rematory or other pla on Nationa	1 Ceme	Date 2/5/2007		gton,	vn, State Virginia
permit. Depart Import eny in	V 3		eee  Masses  Ilications that caused the deat	h. Do not	22. Name and Addre Donaldson 1411 Anna enter the mode of dyi	Funera polis R	load Odent	on, Ma	ryland	21113Approximate
Physician /Medical Examiner		shot, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Que to (or as a conseq	culo	ar Fib	VIIIa:	tion			Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq c	7						
the death certific the attending piched for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			Date of deliver Month	ry Day Year
iuires that the signed by the detail		Part II. Other significant conditions on	ontributing to death but not res	ulting in th	e underlying cause gi	ven in Part I.		tobacco use co Yes 2 □ No	1	e cause of death? ably 4 ∏Unknown
The law req	Completed by	Emphysema	, , ,			/	24a. Was auto peri 1 🗆 Yes		prior to con death?	osy findings available npletion of cause of 2000
Physician: Physician: this certific and director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpa 28b. Tim	e of 28c. Inju	her: 4 🗆 Nursii	Death (Check only ng Home 5 ☐ Res 28d. Describe			')
r Attending fer death. Inector: Afte	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	1		M 1	]Yes 2 □No		(Street and Nu	mber or Rura	l Route Number,
Hospital of the spital of the safe of the	Medicai Ce	29a. Certifier Check only one) Certifier 2 Medical Exam	ysiciam To the best of my kn niner: On the basis of examina and manner stated.	władge d ation and/o	eatr occurred at the tr investigation, in my	me date and popinion, death of	lace, and due to the occurred at the time	e cause(s) and , date and plac	manner as st e, and due to	ated. the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	gunden	W	29c. Licen	se number	-8	29d. Date sig	ned (Month, I	Oay, Year) 3, 2007
6		30. Name and a Press of person who	completed cause of death (Ite NVD 5457) VM	m 23a) (Ty	pe, Print),	uve a	tumpu	am t	2101	15

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 2 2007

32. Segistrar's Signature

			POF	partment of Health and Me ertificate of Death	ntal Hygien	2001 01210
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  LOIS BLAIR	2.	Januar	Day Year 11.17 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	County of Death
Н	Francis		Ellicott City Health & Rehab. Cente 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		. Date of Birth (Month, Day, Yea	Howard  9. Birthplace (State or Foreign Country)
	Funeral Director		439-32-6582 1 M 2 M F 78 Yrs.		(Month, Day, Yea	Country) 1928 Louisiana
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryli f sho	Į.	Maryland Carroll	Marriottsville		1 ☐ Yes 2X No
	n the	irec	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	ath wit	Funerai Directo	7599 Prince Andrew Court	21104		USA
	er dek Items Der m	nne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ Ŵo	<ol> <li>Was Decedent of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was Decedent of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was Decedent of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was Decedent of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was Decedent of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was Decedent of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was Decedent of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was December of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was December of Hispanic Origin? (Specific Management of Hispanic Origin)</li> <li>Was December of Hispanic Origin</li> <li>Was December of Hispanic Origin<td>y Yes or No- can, etc.)</td><td>14. Race - American Indian, Black, White, etc.</td></li></ol>	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
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	filed Hygie Hygie Sther I		17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
<u> a</u>	should be filed within 72 hours after death with the Marylar and Manial Hygiens and Manial Hygiens than "matured other than "natural", or leans 23e or 28a-f show marked other than "natural" for leaning remain cevent, the Mariteal Evanting must be notified at	To Be	William Fanning	Lydia E	bert	
Maryland	2 2 2 3			Ailing Address (Street and Number or Rural R		
	1 and 2 Health tem 27 other tra			9 Prince Andrew Ct.  Sposition (Name of rematory or other place)  Date	-	LSVIIIE, MD 21104 Location - City or Town, State
jo L	Pages nent of int: If it		1 Burial 2 Gremation 3 Removal from State 4 Donation 5 Other (Specify)	rematory or other place) ty Cremation 1/19/2		ykesville, MD
Baltimore,	permit. Pages 1 and Department of Heall Importent: If item 2 any injury or other once.			22. Name and Address of Facility Haight Funeral Home P.O. Box 195 Sykesvi	& Chapel	P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Cardiovacular Poreumonia vele Mellets	12190	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	A have a Notice		
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c. Sevue Dia	vela Melleta		
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20	Je K	dical	d Semlle De	mentin		
9 X O	death certifical e attending phi d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
O. B	0 0 0	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
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Records,	w requires been sign should be	ed by			1 🗆 Yes	2 No 3 Probably 4 Onknown
ec0	e law re has bee je 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		Con			performed2	death?
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1   Yes 2   No	26. Place of Death /(		- FON (0 - 4)
0	g Phy er this	<del> </del>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28c	d. Describe how in	6 ☐Other (Specify) jury occurred
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Division of	i Citte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f	Location (Street : City or Town, Sta	and Number or Rural Route Number, ate)
	spitel		29a. Certifier 12 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and	d due to the cause	(s) and manner as stated.
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To To Com	2	29b. Signature and title of certifier	29c. License number	29d. 0	Date signed (Month, Day, Year)
	9		30. Name and address of person who completed cause of death //sem 22a \ T-iii	2 SU U 41		WI WW 18 2001
	W.		and manner stated.  29b. Signature and title of certifier  E Carm  30. Name and address of person who completed cause of death (Item 23a) (Type Carm School Company School	ack River Neck Re	oad Bo	altimore Maylar
•	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ede		4221
	Registi	ar	JAN Z 4 LUUI			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 5 per fly 29c per 197 (863) 1-22-07 yt Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 3 20 AM Bryant JANUARY 13 200-Regina /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA BALTIMORE SAINT AGNES MOSPITAL Date of Birth (Month, Day, Year) 3–28–1961 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Min 1 □ M 2 F Months Days Hours 220-78-7254 Md. 45 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 □Yes 2 No BALTIMORE Cockysviile Director Md. death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 USA 281 Lord Byron Lane #204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2년 No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after c. Department of health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. the Mannal once. 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bryant Sylvia Α. Samuel ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21223 905 W. Saratoga Street Apt. 1, Baltimore, Md. Mother Sylvia Bryant 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State Arbutus Mem. Park 1-18-07 Arbutus, Md. 4 □ Donation 5 □ Other (Specify) March F.H. East 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ware B 21202 l a 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADULT RESPIRATORY SYNDROME hours Physician /Medical Due to (or as a consequence of): Examiner Days SEPSIS Sequentially list conditions, it any Lating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Days or Attending Physician; The law requires that the death certificate be executed PNEUMONIA and Due to (or as a consequence of): Vital Records, P.O. Box 68760. years the attending physician ACQUIRED IMMUNODEFICIENCY SYNDROME Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 전 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 1□ Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 No Certification: To Division or After this 28b. Time of 28d. Describe how injury occurred 28a Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours at To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 13 2007 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 900 CATON AVENUE MD 21229 MIAC 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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Physic /Med Exam	ical	Decedent's Name (First, Middle, Last)     Marshall Garcia Bennett     4a. Facility Name (If not institution, give street and number)		anuary 1	ay Year 3. Time of Death 3. To Death 4. So The State of Death 5. So The
Funera Directo	_	Bon Secours Hospital  5. Social Security Number  6. Sex  1 M 2 F  7. Age (In yrs. last birthda)  216-74-5147  47  Yrs.		8. Date of Birth (Month, Day, Year 11/24/1959	
the Maryland	Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or I  Maryland  10e. Street and Number	altimore	10-0	10d. Inside City Limit 1
be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or Iteme 23a or 28a-f show event, the Medical Examinar must be malfied.	by Funeral	611 North Calhoun Street	10f. Zip Code  21217  Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R		U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: Black
- 25	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) TMAN	g	Kind of Business/Industry  S. Air Force
	To Be (	17. Father's Name (First, Middle, Last)  Martin I. Bennett Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	18. Mother's Name  Hazel Bivi		
ges 1 and of Health II item 27 or other tr		Hazel Fennett / Mother 5501  20a. Method of Disposition 20b. Place of Disposition 3 Removal from State 5501	None Ave., Baltimor Da amatory or other place)	re, Maryla	ord 21215 ocation City or Town, State
permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lichtee	Forest Ceme.01/24/ 22. Name and Address of Facility The 511 Park Hgts. Ave.,	Derrick C	. Jones F/H,P.A.
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death)  a			Approximate Interval Between Onset and Death
e be executed /sicien and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
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	e Completed	25. Was case referred to medical		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
inding Phyeici ath. ir: After this cer ie funeral direc	To B	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Man of of Death 1 Natural 5 Pending 2 Accident Accident Accident Residue Resi		300	6  ☐Other (Specify)  ury occurred
To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	al Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)  29a. Certifier  1 ☐ Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	City or Town, Stat	s) and manner as stated
To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of dertifier  ACCA	29c. License number  D0040783	d at the time, date an	ate signed (Month, Day, Year)
14		30. Name and address of person who completed cause of death (Item 23a) (Type	MOREVA MED. CT	R. 101	OKAH GREELTS
St Regist	tate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Land s	4/10	- CONTRACTOR OF THE PARTY OF TH

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** JAN Lee Boyd 01:35 M 16 2007 ANTHONY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL ST. AGNES Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 15,1962 219-78-8482 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Director Baltimore Md 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 3100 Windsor 21214 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Boyd Morer th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Boyd Bell Dack Ada 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Prink permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau Ann Allen Baltimore 3100 Windsor arolyn Md altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/19/07 Arbubus Md 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman Harris Funca Home 21. Signature of Euneral Service Licensee 5240 Reisterstown Rd Baltimore Md 21215 Marro 22. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition sulting in death) Liver Cirrhosis **Physician** unknown /Medical Due to (or as a consequence of): Examiner Hepatitis unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Esophageal varicles
Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ drug abuse Intravenous 1 Yes 2 No 3 Probably 4 Nonknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAHMOUD AIDANDASHÎ JAN, 16, 2007 20657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMOUD ALDANDASHI, 900 CATON AVE, Baltimore, MD 21229

Registrar

State

ANTHONY

JAN 2 2 2007 &

31. Date filed (Month, Day, Year)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

William Thomas		(er S	tate of Marylar	nd / Depa		Health					.cgib	16.		
		Registrar  1. Decedent's Name (First, Mid	dlo Lost)	Ce	rtificate of	Death			12	. Date of D	Reg. N	<u>. 20</u>	07	0122
Physicia Medical Exami			Chomas Bal	ker					-	Month January	peath Day 17 2	Year		Time of Death  2004 hrs
and the same of th		4a. Facility Name (if not institut	ion, give street and num			b. City, Tov	vn, or Lo	cation of I	Death	ouridary.	1	4c. County of D		
		10505 Cedarville Ro				Brandy						Prince Geo		
Funeral Director		5. Social Security Number		. Age (In yrs.		If Under	1 Year Days	If Under 2 Hours				M/DD/YYYY) 9		Maryland
Director		214-34-4813 Usual Residence of Decedent	<b>X</b> X M 2 F	70	Yrs.					Nov.	10,	1936	Countr	Maryland
any		10a. State 10b County	/	10c. City	, Town or Locati	on							100	d Inside City Limits
	'n	MD Prin	ce Georges	s   1	Brandyv	ine							1	Yes XX No
Maryla 28a-f d at or	Director	10e. Street and Number				10f. Zip Co	ode				10g C	itizen of What	Country	
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other trammatic event, the Medical Examiner must be notified at once.		10505 Cedary						613				U.S	. A .	
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re, l s 1 and f Heal f item er tra		20a. Method of Disposition  1 X Burial 2 Crematic		20b.	Place of Disposi	tion (Name er place)	of ceme	tery,		Date	200	. Location - Cit	y or Tow	n, State
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Salti ermit epartn mport ijury		21. Signature Funeral Service			22. N	ame and Ad	idre s of	f Facility	Eck	hard	t Fi	nera1	Cha	MD pel P.A.
	9	23a. Part I. Enter the disease, of	or complications that can		111	N COL	ers.	<u>cers</u>	COM	n Ku	• U	rings r	TTT	S, MDZIII
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gicii be	edical	UNPENDED	AMENDED											
Division of Vital Records, P.O. Box 68760 within 24 hours after death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physiconipletely filled in by the funeral director, page 2 should be detached for use as the b	cian/Me	IF FEMALE. 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, ou			al death	3	Ectopic p	regnand	су	2	3d Date of deli Month	very Day	Year
Box 6 e death ce the attend	S		aleanus	nt at time of de	eath 5 Oth	er (Specify	)				1		-	1
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of Vital Records, rg Physician: The law requir ther this certificate has been s meral director, page 2 should i	o Be	examiner?	Hospital: 1 Ing	patient 2	ER/Outpatient		104	h		Home 5	Resid	dence 6 🗸 0	ther: Sce	ené
n of Vi ding Physi After this funeral dir	i.	27 Manner of Death	28a. Date of	f Injury Day, Year)	28b. Time of Ir	jury 280	. Injury a	at Work?		8d Describ		njury occurred		
ision Attendi r death ector: by the f	atio		estigation Jan 17, 20	007	FOUND: 1944 hrs			2 🗸 N	0	ubject Si	iot sei			
Division tal or Attendin 13 after death 14 Director: A	Certification:		ald flot be		ome, farm, stree	t, factory, of	ffice buil	ding, etc.	2	8f. Location or Town	(Street , State)	and Number or	Rural R	oute Number, City
Ospita hours aneral		4 Homicide		Mobile Ho										Brandywine, Md.
Divisior  To the Hospital or Attend within 24 hours after dearth of the Funeral Directors: completely filled in by the	Medical	(Check only   Certifying I	Physician: To the best of aminer:On the basis of											use(s)
To vitl	Mec	29b. Signature and title of certif	and manner sta	ted			icense n					. Date signed		
		Jaska	Dece	P M		(	D.C.M.	E.				nuary 18, 2		
VI		30 Name and address of perso	n who completed cause	of death (Iten	n 23a)				_				-	
IDYI		Tasha Greenberg MI				Penn Stre	eet, Ba	altimore	, MD	21201				
St Regis	tate trar	31 Date filed (Month, Day, Year	94	istrar's Signat	ure	B								
Regis	101	JAN 2 %	2007 June	Marie Street	1					_				

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Brenda Joyce Brittingham January 20, 2007 11:30 AM M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Birthplace (State or Foreign Country)

Ohio

White

Approximate Interval Between Onset and Death

Dav

Year

10d. Inside City Limits

1 ☐Yes 2 🙀 No

Towson

**Physician** \*/Medical Examiner

Greater Baltimore Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 1 □ M 2 🖾 F Days Hours Min. 214-62-7443 Director Yrs. 55 Sept. 2, 1951 Usual Residence of Decedent 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Hammershire Road 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Black, White, etc. 1 ☐ Never Married 2 Married 2 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Office Manager 12 Electric Company Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Robert Johnston, Sr. Catherine McFalls ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Brittingham 505 Hammershire Road, Owings Mills, MD 21117 Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Jan. 26,2007 Hampstead, MD 21. Signature of Funeral Service Licensee 11824 Reisterstown Road 22. Name and Address of Facility ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Physician Breast disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ent of Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown 23d. Date of delivery 3 ☐Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 23e. Did tobacco use contribute to the cause of death? 9 No 3 Probably 4 ☐Unknown Completed 1 🗌 Yes 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 1€0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No Certificat Director: 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Kobert Loregun D0056919 01/20/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G-BMC Suite 205W Kobert Sone Bultimore Mi

32. Registrar's Signature

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

JAN 2 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U / State Amend #9,15,17,18,20a,22, perFH, g863 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RNOOKS Month **Physician** ESSIE :35 A 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMONE CITY MEEN (SMLTIMORE CRENESIS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign S.C. 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛂 720-26-Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location 28a-f ehow the Medical Examiner must be notified at 1 des 2 No MD BATIMORE BALTIMORE CITY Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number or items 23a or A E U&S MELROSE NENU Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK ģ 3 Widowed 4 Divorced 'naturel', Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "n any injury or other traumatic event, its Medi 2008. College (1-4or 5+)
4 years Elementary/Secondary (0-12) EACHER education unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Roberta Suber Carl Suber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genesis Long Green 115 E. Melrose Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ₩Other (Specify) in state /ec Greene I 21. Signature of Funeral Service Licensee
Anthony D. Pleasant tie and Address 21212 Klasar Baltimore, MDApproximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** en Vola /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed for use as the burial-transit Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 Probably 4 Dinknown 1 ☐ Yes 2 ☐ No Completed 24 Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Sing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Inpatient 1 Tyes 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manney f Death 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Aftr completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determin 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 [Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and ad

31. Date filed (Month, Day, Year)

2

200

who completed cause of death (Ifem 23a

32 Registrar's Signature

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			For State of Maryla  State Registrar	•	artment of F rtificate of		lental Hygie	2007	01223
*	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  ROSE G.		BERGER		2. Date of Death	19, 2007	3. Time of Death 7:00 A M
7	Examin		4a. Facility Name (If not institution, give street and number) BRIGHTON OF PIKESVILLE			PIKESVIL		4c. County of Death BALTI	MORE
	Funeral Director		5. Social Security Number  161-03-8001    G. Sex	S. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 07/29/19	9. Birthp Cour	lace (State or Foreign PA
	Maryland I-f show fied at	tor		City, Town or Lo	SVILLE			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 1840 REISTERSTOWN ROAD		10f. Zip Code	21208		Citizen of What Cour	USA
36	rs after des I', or items xaminer m	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ★ No if Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2【 No	dispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of work d) HOMEMAKE	ing	o. Kind of Business/Ind	•
and 21	2 should be filed wi and Mental Hygier Is marked other th aumatic event, the	Be	17. Father's Name (First, Middle, Last) NATHAN	GINSE	BURG		e (First, Middle, Mai	den Surname)	USKY
	nd 2 should alth and Me 27 Is mark r traumation	To	19a. Informant's Name/Relationship (Type. Print)  SCOTT BERGER / SON	19b. Mailir	ng Address (Street	and Number or Run	al Route Number, Ci	ity or Town, State, Zip	· · · · · · · · · · · · · · · · · · ·
Baltimore,	Pages 1 and 2 ment of Health ant; if item 27 laury or other tra		20a. Method of Disposition  1 M Burial 2 CiCremation 3 M Removal from State		osition (Name of matory or other pla RE CEMETE			NKINTOWN,	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	8		TERSTOWN	ROAD - PI	N & BROS., KESVILLE,	MD 21208
\$ 	Physician /Medical	77.0	resulting in death)	nyocard	ler the mode of dyi		or respiratory arrest,		Approximate Interval Between Onset and Death Imunite
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o,	ate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	equence of):					
x 68760,		Physician/Medical	IF FEMALE: 23c. If yes, outcome pf pres	nancy				23d. Date of delive	
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	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not r	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	co use contribute to to	
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or Vita	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Teath  28a. Date of Injury	ER/Outpatier	11 3 DOA	ner: 4 Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how	e 6 Other (Special	iy)
vision	Attending in death.	Certification:	1	t home, farm, str	M 1 □	Yes 2□No	28f. Location (Stree	t and Number or Rura	al Route Number,
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	To the I within 2. To the I complet	Med	29b. Signature and title of certifier		29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
	10		30. Name and address of person who completed cause of death (II	ton of	Print)		KESVILLE,	MD	
	Sta Registr		31. Date filed (Month, Day, Year) 3. Registrar's Signal 1 AN 2. 2. 2007	gnature	Me de la companya de la companya de la companya de la companya de la companya de la companya de la companya de		• • • • • • • • • • • • • • • • • • • •		

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	Physici		1. Decedent's Name (First, Mi	ddle, Last) TELLE			ВІ	RENNE	R			2. Date of De		200 <b>′7</b> <sup>ar</sup>	3. Time of Death 3:15 P M
	/Medio Examir		4a. Facility Name (If not institu	tion, give street a		000		4b. City,	Town, or	Location of		LLE	4c. Co	unty of Death	TIMORE
	Funeral Director		5. Social Security Number 214-34-4404	6. Sex 1 ☐ M 2	7. Ag		last birthday) 3 Yrs.	If Under Months		If Under		8. Date of Birt (Month, Da 08/07/	, 1923		place (State or Foreign
	ryland how at		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	h the Ma r 28a-f s notified	irecto	MD N/	Α		BAI	-TMORE	Ba 10f. Zip	Ltimo:	re			10g. Citizen	of What Cou	1 X Yes 2 No
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Maryland	nould be filed within I Mental Hygiene. narked other than natic event, the M	To Be (	17. Father's Name ( <i>First, Midd</i>	lle, Last)		ŀ	18. Mother's Name (First, M				(First, Middle,	Maiden Sur	rname)	LEVIN	
Mary	1 and 2 should I Health and Men tem 27 is market other traumatic		19a. Informant's Name/Relation							STRE		16-G			NY 10024
<b>Baltimore</b>	Pages 1 au nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Crematic 4 ☐ Donation 5 ☐ Othe		I from State	C	lace of Dispo emetery, cren	natorý or o	ther plac			3/2007		on - City or To	
Balti	permit. Pages Department of Important: If II any Injury or once.	1000010					22. Name and Address of Facility SOL LEV 8900 REISTERSTOWN ROAD						NSON &	, INC.	
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8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	°	5	E12	E \ Z J RES a consequence of):								years
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number					oinion, dea	th occurr	ed at the time,	date and pla	ce, and due to	the cause(s)					
	To To	2	29b. Signature and title of cert	ifier				290	. License	number	F		29d. Date sig	gned (Month,	Day, Year)
	T		30. Name and address of pers	on who complete	d cause of de	eath (Item	23a) (Type 1	Print)	00	351.	10	- 1	JAN	1747	2007
6	7		ShALLINA	1 ACM	GUP-	r A	965	O 5+	AN7	116	0 R	COAD	COL	UMBI	A 21045
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shallow NALA GUPTA 9650 SANTIAGO ROAD  State  Registrar  31. Date filed (Month, Day, Year)  AN 2 2 2007  32. Registrar's Signature															

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year LOUISE BERRY TAN 4:55A M 1 0 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death ULIVERSITY Speciality BACTIMORE DITAL ast birthday) 5. Social Security Number Age (In yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/10/1937 9. Birthplace (State or Foreign 70 Yrs Months Days Hours Min 1 □ M **XCX**F 419-44-1613 ALABAMA Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits MD N/A 1 Yes 2 □ No BALTIMORE CITY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? S. CHARLES STREET 21230 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces 1 ☐ Never Married 2 ☐ Mamed Yes 2 No Yes, Give 1 ☐ Yes ¾ No Specify. If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☑ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHEF FOOD SERVICE 11TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TELLIF OWENS MARY ALICE GLEEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA CAMPBELL/DAUGHTER 2408 RIDGELY ST., BALTIMORE, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) METRO 1/19/07 CREMATORY CATONSVILLE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Part Falter the diser shock, or heart failure se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jardiac arrythomas disease or condition resulting in death) 15 mmus Due to (or as a consequence of) there sclerotic 544 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a amal 11 hrmic Due to (or as a consequence of): 11 Hyper Knska IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Day Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dicholes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ ▶ 6 24a. Was an autopsy performed? Yes 2 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

1 ☐ Yes 2 ☐ No

103041914

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1/10/2006

Physician /Medical Examiner Examine and

**Physician** 

Examiner

**Funeral** 

Director

show

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

and Mental Hygie is marked other

Department of Health a Important: If item 27 is any Injury or other trau

and 2 should be

Pages 1

Maryland 21215-0036

Baltimore,

Box 68760,

Division or Vital Records, P.O.

/Medical

Director

Funeral

2

Completed

Be

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burial-tran physician the as attending use for ed by the a signed b page 2 should has been certificate After this funeral

g

Hospital or Attending within 24 hours after deatn.

To the Funeral Director: Af

Physician/Medical 3 Completed Be 2 Certification:

> 3 State

\* DESAI MO 31. Date filed (Month, Day, Year) JAN 2 0 2007 Registrar

29b. Signature and title of certifier

2 Accident

4 ☐ Homicide

(Check only

3 ☐ Suicide

29a. Certifier

investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

USH 601 Registrar's Signature

south charles of Baltman mox 1230

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

14. Race - American Indian. Black, White, etc. Specify: white 16b. Kind of Business/Industry

Country, NY

2007

4c. County of Death

Baltimore

10g. Citizen of What Country?

1922

USA

3. Time of Death

5:15a

9. Birthplace (State or Foreign

10d. Inside City Limits

1 □XYes 2 □ No

Reg. No.

19a. Informant's Name/Relationship (Type. Print) Chris Chamberlain (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2142 Ironworks Pike, Lexington, KY 40511

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation 1-20-07

20c. Location - City or Town, State Sykesville, MD

domestic

Parge Hargest o 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

22. Name and Address of Facilit Haight Funeral Home & Chapel P.O.Box 195, Sykesville, MD 21784

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): ardiom Due to (or as a consequence of):

11001

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Year

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 9☐Unknown

3 □Ectopic pregnancy 5 ☐ Other (specify)

23d Date of delivery Day Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

1 Yes 2 No 3 Probably 4 ☐ Unknown

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

24a. Was an 1□ Yes 2 - No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

5 Pending investigation

6 ☐ Could not be

determined

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

27. Manner of Death

1 Natural

2 ☐ Accident

3□ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

FERNANDO

29c. License number クタステノナ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) JAN 2 2 2007 32. Registrar's Signature

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra

**Physician** 

/Medical

Examiner

attending physician and for use as the burial-tran

signed by the ar

after death.

Director: After this certifications

To the Hospital o within 24 hours aff To the Funeral Di

Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month  $1^{a}$ 2007 3:30р. м Carroll Albert Charles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 2934 Stranden Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) M.D. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral X**□M 2□F Days Hours 38 MD Yrs. Director 215-74-5264 68 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore NA 1 XYes 2 No Md. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21230 2934 Stranden Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E. Brown Carroll Helen William Η. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2934 Stranden Road, Baltimore, Md. Brother Haold Carroll 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Catonsville, Md. Western Star Cem. 1-20-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North 21202 North Ave, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of) Examiner 46 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes certificate has been si rector, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1∐ Yes 2 • No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence this 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending Fafter death. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifie

30 Name and address of persop who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 7

			For State Registrar	State o	of Mar	yland /		artmen tificate			nd M	ental Hygi	ene (	07	012	28
	Physicia		1. Decedent's Name (First, Middle, L	_ast)		·		2				2. Date of Death Month	Day	Year	3. Time of I	
	/Medic	al .	Kelton		D.			Cross	T	1 4: 4	Death	JANUARY		2007	17:3	/ FM
	Examin	er	4a. Facility Name (If not institution, g  Union Memor	rial Hos		1				Location of imore	Death		40.000	NA		
-	Funeral			. Sex		In yrs. last i	birthday)	If Under	1 Year	If Under 2		8. Date of Birth	Voorl	9. Birthp	place (State or	Foreign
	Director		213-94-7593	1 <b>X</b> M 2 ☐ F		42	Yrs.	Months	Days	Hours	Min.	(Month, Day, 4-11-1	964	Cour	Md.	
	D .		Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, To	wn or Lo	cation						1	IOd. Inside Cit	y Limits
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	the N	Director	10e. Street and Number	-				10f. Zip				10	g. Citizen	of What Cour	ntry?	
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9	filed within 72 hours after Hygiene. other than "natural", or Ite ent, Ine Madical Examina	by Ft	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes If Yes, G Year or D	2X∏No ive			1 🗆 Yes		Specity:			Spe	ecify: B	lack	
Ş	hour tural'		15. Decedent's		Jates:	16	Sa. Deced	dent's Usua	al Occupa	ation			6b. Kind o	f Business/In	dustry	
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yland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	st)		One						(First, Middle, M		name) nite		
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<u> </u>	d2st than than 17 is n traun		19a. Informant's Name/Relationship Novella Ward	Sist	er			-				., Apt.				
ย์	ton 2		20a. Method of Disposition			20b. Place ceme								on - City or To		
Ē	Pages ent of nt: If I		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	]		mel C			1-20	<b>-</b> 07	Dunda	alk, Mo	đ.	
Бапппо	permit. Pages 1 and 2 should be filed within Department of Health and Mandal Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, it a Mange.		21. Signature of Funeral Service Lic	censee						s of Facility		March F.				
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	Examiner		Sequentially list conditions	b/	ACQ	VIRE	ED	Imn	nun	oder	ficie	ency s	yna	KOME	5 YE.	ARS
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	flicate g phys			d												
X Q	death certifica e attending ph d for use as th	M/UR	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or		pregnancy	ath 3.「	∃Ectopic p	reanancy				23d.	Date of deliv	-	/
n	e deat he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at ti	me of death		Other (sp						Month	Day Y	'ear
J Ö	hat the d by t setach	Phy	9 Unknown  Part II. Other significant condition	s contributing to	death but	not resultin	a in the u	inderlying o	ause dive	en in Part I		23e. Did tob	acco use o	contribute to t	the cause of de	eath?
Ġ,	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as th	d by	Takin. Salar signment contains	- 0011111041111g to	2020.		9		acco g				s 2 N		bably 4 ⊟U	
Hecords,	w req	Completed										24a. Was ar	24	4b. Were auto	opsy findings a	available
Ä	hysician: The law his certificate has b I director, page 2 s	ошо							-			autopsy perform	ned? No	prior to co death? 1 ☐ Yes	ompletion of ca	ause of
	<i>a □</i>	0	25. Was case referred to medical							26. Place	of Death	(Check only one				
<b>o</b>	Physician: this certific ral director,	To B	examiner? 1 🗌 Yes 2 🖟 No		Inpatient		_	nt 3 DC		4 🗀 1401		me 5 ☐ Reside			fy)	
	ding Ph h. After th funeral		27. Manner of Death 1   Natural 5 □ Pending		e of Injury onth, Day	Year) 281	b. Time o Injury		28c. Injun Worl			28d. Describe ho	w injury oc	curred		
Division	Attending r death. ector: After by the fune	Icat	2 Accident investiga 3 Suicide 6 Could no	ot be 29a Plac	e of Injur	y - At home	farm st	M reet factor		Yes 2 1		28f. Location (Sti	reet and N	umber or Rur	al Route Numi	ber.
<u>&gt;</u>		Certification:	4 ☐ Homicide determin	ed built	ding, etc.	(Specify)	, 141111, 31	reot, factor	y, omoo			City or Town				
	To the Hospital or within 24 hours after to the Funeral Dircompletely filled in		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the	bacin of a	vamination	and/or in	wootanting	in my o	oinion deat	th occurr	ad at the time da	to and ola	co and due t	in the causole	)
	To the Hos within 24 h To the Fun completely	Medical	one)	and ma	inner state	ed.	: 1-	V 1 29	c. Licens	e number		6-681 moriac D 212	d. Date si	gned (Month,	Day, Year)	
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	n .		30. Name and add e s of person w	no completed ca	use of dea	ath (Item 23	a) (Type.	, Print)	Un	150	ME	MORIAL	- H	OSDI+	716	0 /
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	Regist	rar	JAN 2 2 2	100/	100	And "	A STATE OF THE PARTY OF THE PAR									

07-00125 Gerry Crosby

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar_	te of Death	, 0	a No O O	7 0100
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)		Date of Deat     Month	h Z-U Year	3 Time of Death
wedicai Exami	ner	GERRY CROSBY  4a. Facility Name (if not institution, give street and number)	4b City, Town, or Location of	January 5,	2007 4c County of Death	1111 hrs
		Mercy Hospital	Baltimore	Death	N/A	
Funeral		5 Social Security Number 6. Sex 7. Age (In yrs. last birth			h(MM/DD/YYYY) 9 Birth	hplace (State or
Director		215-68-2863   1XXM 2 F   50	Yrs. Months Days Hours	Min 07/13/	1956 Foreign	MARYLAND
any		Usual Residence of Decedent  10a State 10b. County 10c. City, Town o	Location			40d 1d- Otto 1d-
ž .						10d Inside City Limits 1 XXYes 2 No
daryland 28a-f show 1 at ouce.	양	MARYLAND N/A BALT  10e. Street and Number	IMORE 10f. Zip Code		Og Citizen of What Coun	1
th the Maryland 23a or 28a-f she	Director	1716 MURA STREET	21217		U.S.A.	
with ms 23.	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origi		14. Race - Americ	an Indian, Black,
r death or ite	Funeral	1 XX Never Married 2 Married Armed Forces?  1 Yes 2 X No	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	White, etc	
rs afte ural",	虿	Widowed 4 Divorced If Yes, Give Year or Dates.  15 Decedent's Education (Specify only highest grade completed) 16a. D.	1 Yes 2 X No specify: ecedent's Usual Occupation (Give ki	ind of work done	Specify. BLAC	
72 hou	Completed		uring most of working life. DO NOT u		TOD: KING OF BUSINESS/II	dustry
0036 within jiene.	d m	9th grade	N/A		N/A	
IS-0 filed v Hygid d othe		17 Father's Name (First, Middle, Last)	18.Mother's	Name (First, Middle, M	laiden Surname)	
D 2121 should be fi and Mental 7 is marked	o Be	ART CROSBY  19a Informant's Name/Relationship (Type, Print )  19b.	LOU I Mailing Address (Street and Numb	SE WILLIAM		7.0.1)
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygene. titen 27 is marked other than "natural", or items 23a or 28a-f shr traumarie event, the Medical Examiner must be notified at once	-		311 Goldmeadow Wa			
ore, M es I and 2 of Health of Health If item 2		20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery, y or other place)	Date	20c. Location - City or T	
MOI Pages lent of luft: I	П	Temoval non otate	CREMATORY	01-22-07	BALTIMORE,	MARYLAND
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	1	21. Signature of Funeral Sarvice Licensee	22. Name and Address of Facility WM_C_BROWN_COMM			
		23a. Part Polici the lisease, or complications that caused the death. Do not	321 S PHILADELE	PHIA BLVD,	ABERDEEN, M	D 21001
Physician /Medical		failure. List only one cause on each line.		rdiac or respiratory arre	st, snock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Cardiac arrhythmia du  Due to (or as a consequence of):	e to cardiomegaly			Deall
, /		Sequentially list conditions, b				
	nine	If any, leading to immediate  Due to (or as a consequence of):  Cuss F for It of mying Coust  C.				
√ gg √	Examiner	(Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):			<del>-</del> .	
760, icate be executed physician and the burial - transit		MENDED AMENDED 27				
760, ficate be ex- g physician the burial	/Medical	X UNPENDED AMENDED #23a,27,per/IE, g8 IF FEMALE. 23c. If yes, outcome of pregnancy	66, 4/19/07 TT		23d Date of delivery	
		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic	pregnancy	Month Da	ay Year
Box 68 s death certiff the attending ed for use as r	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
O. Bat the data the tached		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part	t I. 23e. Did to	bacco use contribute to the	ne cause of death?
, P.C	d by			1 Yes	2 No 3 Proba	ably 4 Unknown
ords, w requires been s should	lete			24a. Was a		opsy findings available ompletion of cause of
RecC The lavate havage 2	Completed			perform	med? death?	
Division of Vital Records, P.O rat or Attending Physician: The law requires that its after death  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be dena	BeC	25 Was case referred to medical examiner?	26.Place of Death (0	Check only one)		L
of Vit g Physic fter this	2	1 Yes 2 No Inpatient 2 V ER/Out			Residence 6 Other	
nn of Iding Pl th : After e funera	ö	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Ti	me of Injury 28c. Injury at Work?		ow injury occurred	
isior	icat	2 Accident Investigation 28e. Place of Injury - At home, farm	m, street, factory, office building, etc.		treet and Number or Rura	al Route Number City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifurities about safter death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined (Specify)	, , , , , , , , , , , , , , , , , , , ,	or Town, St		a reduce rearriber, only
e Hosp 124 ho e Fuue etely f		29a Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated	i
To the b within 2 To the b	Medical	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated		urred at the time, date a		
	2	29b. Signature and title of certifier	29c License number O.C.M.E.		29d Date signed (Mont	h, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	J.O.IVI,E.		January 6, 2007	
8			11 Penn Street, Baltimore,	MD 21201		
	ate	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	1			
Regist	-	JAN 2 2 2007   Mages &	Accept !			
DAMMATT BULLET	OU.	ORK	JINAL			

Roll III.00 OCME 2006

			1 - For State Registrar	State of Marylar		artment of rtificate o		Mental Hy	rgiene Reg. No.	<i>-</i>	0,200
	Physici	an	1. Decedent's Name (First, Middle, Last) John A. Cacace	)				2. Date of De Month	eath Day	Year	3. Time of Death 10:40 A M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4h City Town	, or Location of De	Janua		2007 ty of Death	10.40 AM
100	Funeral Director	iei	Crofton Convalesce 5. Social Security Number 6. Sec	ent Center		_	ofton ar   If Under 24 H	rs. 8. Date of Bi	Anne	9. Birthp	nde1 place (State or Foreign ptry) y York
	P .		Usual Residence of Decedent					Берс.	21,1907		
	arylar ahow	_	10a. State 10b. County		ty, Town or Lo	cation				1	Od. Inside City Limits
	he M	ecto	MD Prince (	Georges ]	Bowie						1 □XYes 2 □ No
	with	급	10e. Street and Number 12306 Firtree Lar			10f. Zip Code			10g. Citizen of		ntry?
	Jeath The 23	Funeral Director		12. Was Decedent Ever in U	.S. 13. V	2071		Specify Yes or No	USA 14. Ba	Ace - Americ	an Indian.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental thygiene.  If Item 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumatic event, the Madical Examinar must be notified at	by	1 Never Married 2 Married 3	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Ci	f Hispanic Origin? i uban, Mexican, Pue o Specify:	erto Rican, etc.)		ack, White, ify: Whi	etc.
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	ient's Usual Occ	upation le during most of w	orkina	16b. Kind of	Business/Inc	dustry
21	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use reti	red)	Orking			
	Hygier Hygier Ither th	S	17. Father's Name (First, Middle, Last)		Chie	f Clerk	40.14-15-1-14	47 <sup>m</sup>	Shippi		
Maryland	d be find he do	Be						ame (First, Middle	, Maiden Suma	.me)	
Ž	should be and Mental marked o	2	John Cacace  19a. Informant's Name/Relationship (Ty	pe Print)	19h Mailin	ng Address (Stre	Mary et and Number or I	Gambino	er City or Town	- Stato Zin	Codel
S S	and 2 sho saith and n 27 is m		Michael Cacace/ Sc					Bowie, M			(2006)
ē,	f Healten		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of natory or other p		Date	20c. Location		wn, State
Ę	Pages nent of l int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		ematory		22/2007	Wald	orf,	MD
Baltimore,	무원들 .		21. Signature of Funeral Service License			. Name and Add	15 10	Robert E.			
m	Depe Impo any I		LUM			16000 A	nnapolis	Road Bo	wie, MD	runer 207	
п			23a. Part 1. Enter the disease, of compli- shock, or heart failure. List only or	calions that caused the deat							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Good	Stan	o. Dos	mantia			h	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):			)			1
	-Adminici	-	Sequentially list conditions, if any, teading to immediate	Due to (or as a conseq							
	ted nsit	nine	rany, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence or);						
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				-		
68760,	cate be ex physician the buria	salE									
		edicai									
Вох	The law requires that the death certific lie has been signed by the attending pi page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		C-t			23d. D	ate of delive	ry
	ed for	sicia	in the past 12 months?  1  Yes 2 No	4☐Pregnant at time of d		Ectopic pregnar Other (specify)			М	onth	Day Year
P.0	that the de led by the a detached t	Phy	9 🗆 Unknown								
	signed to be det	þ	Part II. Other significant conditions con	Inbuting to death but not res	ulting in the ur	iderlying cause of	given in Part I.				e cause of death?
Records,	w requir been s should	Completed						1	Yes 2. No	3 Prob	ably 4 □Unknown
3ec	e taw has b	mple				·		24a. Was autoj	psy	prior to con	osy findings available npletion of cause of
a	r: Th icele r, pag							1 ☐ Yes	2 No	death?	2□ No
of Vital	nding Physician: The la th. : After this certificele has s funeral director, page 2	Be c	25. Was case referred to medicat examiner?	ospital:		_ 0		eath (Check only o			
	Physical distriction	. To	1 Yes 2 No	1 Inpatient 2 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	28c. Inj W	4.EQ Nursing	Home 5 Resi	dence 6 ⊡Ot how injury occu		')
Division	ath. r: Afte	Certification:	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ☐ Yes 2 ☐ No		. ,		
Vis	after deatl	Iffica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al ho building, etc. (Specifi	ome, farm, stre	et, factory, office	9	28f. Location (	Street and Num	ber or Rura	Route Number,
ā	tal or rs afte al Dli ed in	Cer		building, etc. (Special	,, 			City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place,	anner as sta	ated. the cause(s)
	o the	Me	29b. Signature and title of eartifier	A and marrier stated.		29c. Licer	nse number		29d. Date signe	ed (Month, L	Dav. Year)
	- s + ō		1 Som			D	40519		1/2210		**
15	1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type 5	Print)	· · · )		1/6210		
1	7		1401 Madaisun Park				Mirza Ni	isarre, L	C		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	turo	and I					

			Plea	se Type or Pr							_				
		-	For State Registrar	State of M	Marylan		artmen rtificat			and M		Reg. No	71111	012	31
W.	Physicia		Decedent's Name (First, Middle Rosalie Cager	e, Last)							2. Date of De Month	Da		3. Time of 1	Death M
1	/Medic Examin		4a. Facility Name (If not institution	, give street and numbe spital	ar)		-	Town, or	Location of	of Death	,	-	. County of Death		-
*	Funeral Director		5. Social Security Number 217-16-1208	6. Sex 7 1 ☐ M 2 <b>X</b> ☐ F	Age (In yrs. i		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 01/29/	ay, Year,	9. Birth Cou	place (State or ntry) MD	Foreign
	Maryland f ehow	lor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City	y, Town or Lo		Baltin	nore					10d. Inside Cit	
	with the I a or 28a- Le notifi	Director	10e. Street and Number 705 North Woodingt	on Road			10f. Zip		21229			10g. Ci	tizen of What Cou USA	ntry?	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other then "natural", or Items 23a or 28a-f show or other fraumatic event, fra Medical Example mutilize notified at	by Funeral	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced		s? XNo		Was Decedif Yes, spe	cify Cuba	spanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White,	etc.	ican
Baltimore, Maryland 21215-0036	hin 72 hours b. "natural" Medical Ex	Completed b	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done d	turing mos	t of work	ing	16b. F	(ind of Business/Ir		
id 21;	filed with Hygiene other the	Be Com	12th 17. Father's Name (First, Middle,				super	rvisor		er's Nam	e (First, Middle	<del></del>	janitorial n Sumame)	service	
ırylar	should be ad Menta marked matic ev	ToB	Lawrence	e Schley hip (Type, Print)		19b. Maili	ng Address	s (Street a	and Numbe	er or Rur	Elizabe		nable or Town, State, Zi	code)	
e, Ma	t and 2 stealth ar		Michele Williams /		20b. P	705 Place of Dispo			lingtor		d; Baltin Date	,	Maryland ocation - City or T		
imor	Pa pi t		1 Burial 2 Cremation 4 Donation 5 Other (S	pecify)	ate C	emetery, crea	n Cemet	other plac tery	(	01/24	/2007	Bal	timore, Man	ryland	
Bail	permit. Departn Imports any inju		21. Signature of Funeral Service	Licensee		2:	2. Name ar 638 N			-			ral Home, l aryland 21		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or	as a consequence A cute	lummas uence of):		num		cardiac	or respiratory	arrest,		Approximate Interval Betv Onset and E	veen
P.O. Box 68760	I the death certificate be executed by the attending physicien and ached for use as the burial-transit	Physiclan/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	d	n 2 ∏Feta tat time of d	il death 3	⊒Ectopic p ⊒ Other (s <sub>j</sub>						23d. Date of delik Month	•	'ear
of Vital Records, P	The law requires that the deate has been signed by the bage 2 should be detached	ρ	Part II. Other significant condition	cell lung	cance		underlying (	cause give	en in Part I			Yes 2	use contribute to	babiy 4 👰	inknown
al Rec	The lar ate has page 2	Completed									aut	opsy formed?	prior to o death?	ompletion of ca	
fVita	nysician: Th nis certificate I director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Minp	atient 2	ER/Outpatie	nt 3 D	OA Oth	00		th <i>(Ch</i> eck only ome 5□Res		6 □Other (Spec	fy)	
Division o	To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director.	ertification;	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation not be 280 Place of	Day Year)	28b. Time of Injury	М		yat k? Yes 2 □	No	28d. Describe		ary occurred	al Route Num	ber.
Ďi∨	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	O	4 ☐ Homicide determ  29a. Certifier 1 ™ Certifyir		, etc. (Specil	<b>(y</b> )			ne, date ar	nd place,	City or T	own, Sta	te)		
	the Hosthin 24 hosthin 24 hosthin 24 hosthin Full	Medical	(Check only 2 Medical one)  29b. Signature and title of certifie	Examiner: On the basi and manner		ation and/or in			pinion, dea e number	ath occur	red at the time		nd place, and due ate signed (Month		)
	N 8 2 ½ 3		Bichhuon	M. Pinh					4996			-		, 2007	
	)		30. Name and address of pe on Bichhuong M.  31. Date filed (Month, Day, Year	Dinh (	of death (Iter 200 S pistrar's Signa	. Cato	n Av	/e.,	Balti	more	, M92	122 Q			
	Sta Regist		JAN 2 2 20			done l	er_								

P.O. Box 68760, or Vital Records,

JANUARY

filled in by the

Hospital or Attending within 24 hours after death To the Funeral Director:

State Registrar

29a. Certifier

(Check only one)

29b. Signature and

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

JAN 2 2

title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007



📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

07-00378 Richard Crane

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ard Crane		State of Maryland / Department of He 1- For State Certificate of De		Reg. No.	7 0100
Physicia dical Exami	an/	1. December 1's Name (First, Middle Last)	2. Date of Month Janus		3 Time of Death 2 3
			ty, Town, or Location of Death	4c. County of Death	,
Funeral Director	7 I	216-06-4236 1XM 2 F 36 Yrs. M	Under 1 Year If Under 24Hrs. 8. Date on this Days Hours Min	of Birth (MM/DD/YYYY) 9 Birth -29-70 Foreign Cou	hplace (State or number)
nd show any ice.	-	Usual Residence of Decedent  10a. State  10b. County  Raution  Raution	ore		10d. Inside City Limits 1 Xyes 2 No
ith the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number 1500 E. 29th Street 10f.	2/2/8	10g. Citizen of What Coun	try?
r death w or items must be	y Funeral	1 Never Married 2 Married Armed Forces? If Yes, sp	edent of Hispanic Origin? (Specify Yes secify Cuban, Mexican, Puerto Rican, et 2 No specify:		can Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after dement of Health and Mental Hygiene taut: If item 27 is marked other than "natural", or or other traumatic event, the Medical Examiner m	Completed by		ual Occupation (Give kind of work done working life. DO NOT use retired)	16b. Kind of Business/li	ndustry
21215-0036 Uld be filed within Mental Hygiene marked other than r event, the Medics	Be Com	17. Father's Name (First, Middle, Last)	18 Mother's Name (First, M	iddle, Maiden Surname)	K
ore, MD 21 s. I and 2 should of Health and Mer If item 27 is man	То	19a Informant's Name/Relationship (Type, Print)  19b. Mailing Add  1500  20a Mathod of Disposition  20b. Place of Disposition	E.2945 St. B	te Number, City or Town, State,	Zip Code)  /2/8  Town State
Baltimore, permit Pages I a Department of He Important: If ite		1 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	ial fart 1-19-0	1 100 177	pre, MD
		hun W. Sur	905 Work Rd	Ralto MD	21212
Physician /Medical Sxaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the month failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Multiple Gunshot Wounds  Due to (or as a consequence of)	de or dying July as cardiac or respirat	ory arrest, shock, or heart	Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ecuted and - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy		23d Date of delivery	
Box 687 e death certific the attending p	sician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown  1 Live birth  2 Fetal de 4 Pregnant at time of death 5 Other (9)	eath 3 Ectopic pregnancy Specify)	Month C	Year Year
P.O. Borres that the designed by the signed for the sig	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the under	, ,	Yes 2 No 3 Prob	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death 170 the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Completed				topsy findings available ompletion of cause of s
Ttal Re(sician: The is certificate irector, page	Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only one)  DOA Other Nursing Home	5 Residence 6 Other	
on of V ending Physath or: After thi	tion: To	27. Manner of Death  1 Natural 5 Pending  28a Date of Injury Jan 13, 2007  28b. Time of Injury 1244 hrs	28c, Injury at Work? 28d De	scribe how injury occurred	
Division pital or Attendi ours after death teral Director: A	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street		ation (Street and Number or Ru own, State) ock East 29th Street, Baltim	
To the Hos within 24 h To the Fun completely	Medical (	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred a one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.			
	M	29b. Signature and title of certifier  Partial Anythan. MA	29c. License number O.C.M.E.	29d Date signed (Mor January 14, 2007	
3		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 P.	enn Street, Baltimore, MD 212	01	
S Regis	tate				
HMH 17 Rev 1/		ORIGINAL			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** COFFIN JANUARY P. 2°0′0 7 JOHN 7:20 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 9. Birthplace (State or Foreign Country) MD ear If Under 24 Hrs. 5. Social Security Number 8. Date of Birth . Age (In yrs. last birthday **Funeral** Months 1**√** M 2□ F Min. Davs Hours 01713/1944 63 213-42-3272 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1120 GREENWAY ROAD 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PARALEGAL LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be COFFIN MARY YATES LANSING HENRY NELSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 GREENWAY ROAD - COCKEYSVILLE, MD 21030 ESTHER MILLER / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 01/19/2007 BALTIMORE HEBREW CEM REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 cations that seed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1 Enter the disease, or com shock, or heart failure. List only 23a, Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heamonio 4 WKS /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. First underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Exami burial-trar and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) or Vital Records, P.O. 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has performed' certificate 21 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 1 ☐ Yes 20 No 2 ER/Outpatient 3 DOA ဥ 1\_Impatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 27. Manner of Death Date of Injury After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending (Month, Day Year) Injury 1 → Natural 5 Pending investigation death. 1 □ Yes 2 □ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670 im oth

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

07-00453	07-	00453
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lendora Delores Davis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Deaft Month Day January 16, 2007 Medical Examiner 1632 hrs Delores Davis Lendora 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2518 North Edgecombe Circle Apt. C Baltimore 5. Social Security Number 8. Date of Birth (MM/DD/YYYY **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Foreign Months Days Hours Min Director 06 59 08 260-31-8187 X F 47 MD M Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 XYes 2 No Baltimore MD NA with the Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 2518 Edgecombe Circle Ö 21215 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 72 hours after death Armed Forces? White, etc. 1 X Never Married 2 Married Yes Yes 2X No specify Widowed If Yes, Give Year Black 4 Divorced Specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than ", Complet Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha injury or other traumatic event, the Medic 2th grade Certified Nurses Asst. Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Be Estella Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Circle, <u> Ieishia Henriques-Dauqhter</u> 2518 Edgecomb Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 King Memorial Park 1/23/07 Randallstown, Md Other Specify Donation 5 Name and Address of Facility 21 Sign ture of Funeral Service Licenses hw£65sh 358 St Ave, Baltimore, 21215 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): n and transi executed sician/Medical physician a UNPENDED AMENDED The law requires that the death certificate be Box 68760. IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown Unknown the P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Yes 2 ✓ No 3 Probably 4 Unknown Records, Completed this certificate has been s 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No No the Hospital or Attending Physician; thin 24 hours after death. 25. Was case referred to medica 26. Place of Death (Check only one) Division of Vital Be Hospital: 1 Other; Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 ✔ Yes No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural 1 Yes 2 No 5 Director: d in by the f Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) within 24 hours a To the Funeral L (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) hanner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 17, 2007 30. Name and address eted cause of death (Item 23a) f person who com Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registra DHMH 17 Rev 1/2001

**OCME 2006** 

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 8864 2-5-07 vt. State of Maryland Department of Health and Mental Hygiene 1 ment of tem 5 per fh 8864 2-22-07 vt. Reg. No. 1 - For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1<sup>Day</sup> Month 2007 9:45p.M **Physician** Diggs Gertrude /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 4223 Oakford Ave If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security No. 1818 7. Age (In yrs. last birthday) 6. Sex Hours **Funeral** Days Months 1 ☐ M 2 🔀 F 74 32 MD 17 10 Director 218<del>-56-2818</del> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at XXYes 2 ☐ No Baltimore MD NA Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 4223 Oakford Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify Specify: Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Center L.P.N. 2yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada Locks Goalds S. Wilson 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 21215 4223 Oakford Ave, Baltimore, Md Charles Diggs Jr. Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Garrison Forest Vet 1/23/07 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md arci 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to imme liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ¥o 24a. Was an autopsy performed?

1 Yes 2 No has this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, to 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural
2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Bleel Balto med 21239 Davis talin 5601 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2 2007 Registrar

07-00486 Lance Richard D	iam		<b>e or Print in Bl</b> ite of Maryland						egible		
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Physicia	an/	Registrar 1. Decedent's Name (First, Middle	,Last)					2. Date of D			3. Time of Death
Medical Exami		Lance Ric	chard	Diam	ond		Sr		18, 200		0844 hrs
14		4a Facility Name (if not institution 7830 E. Hill Road	, give street and number)			4b. City, Tow Mount A	n, or Location o	of Death		County of Death	1
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imore, MD 21215-0036  Peges I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		Linda Diamond 20a Method of Disposition	wi	fe		Ridge osition (Name		. Airy, M		771 ocation - City or	T- Ol-1-
Baltimore, nermit. Pages I an Department of Hea Important: If iter		1 X Burial 2 Cremation	3 Removal from St	ate	crematory or	other place)		Jan 24 20		ocation - City or	Town, State
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	(	niner: On the basis of exa								
F3F8	Š	29b. Signature and title of certifie		^ ^			icense number		29d E	ate signed (Mo	nth, Day, Year)
		Pater le	enica-te	Alle	l mo	(	D.C.M.E.		Janu	ary 19, 200	7
		<ol> <li>Name and address of person Patricia Aronica-Pollak</li> </ol>		,		▶111 Per	n Street. Ba	altimore, MD 212	201		
S	tate	31 Date filed (Month, Day Year)	-		1.	Jode .	, 50				· <del></del>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ICKIE 2007  $4:35PM^{M}$ Jan 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 3427 Lyndale Ave. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Days Hours **Funeral** Months 1 □ M 2 🔀 F S.Carolina Director 218-62-5120 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State 10h. County r 28a-f show notified at 1 XYes 2 No Director Baltimore Md. N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be r 21213 USA 3427 Lyndale Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Black 1 ☐ Yes 2X No Specify Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) John Hopkin Hosp. 12 Therapist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian B. Kingwood Lee Kingwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3427 Lyndale Ave, Baltimore, Maryland 21213 Joseph Dahn Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/27/07 Arbutus, Md. Arbutus Mem.Pk. 22. Name and Address of Facility
Estep Brothers Funeral Ser, P.A.
1300 Eutaw Place, Baltimore, Md. 21. Signature of Funeral Service Licensee 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTA Physician /Medical Due to (or as a consequence of) REAS! Examiner Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ig physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed I ector, page 2 should be det Completed by Unknown 2 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 TNo 24a. Was an autopsy performed? page or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl funeral director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 🗌 Homicide within 24 hours af

To the Funeral D

completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifie

30. Name and address of person

the

29d. Date signed (Month, Day, Year)

07-00301 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dora Edwards State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg No. Registrar . Decedent's Name (First, Middle, Last) Date of Death Physician/ Month Day January 11, 2007 0508 hrs Medical Examiner Edwards 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7420 Marlboro Pike Room 242 District Heights Prince George's 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 2 X F Dec 24, 1935 Washington, DC М 577-50-1293 Usual Residence of Decedent 10b. County Oc. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Capitol Heights 1 X Yes 2 or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyggene irenants, or items 21 is marked other than "natural", or items 25a or 28a-f sho trannarite event, the Medical Examiner must be notified at once. rector 10e Street and Number 10f. Zip Code 10g Citizen of What Country ä 1000 Barnsbury Court 20743 United States ē Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in LLS 14 Race - American Indian, Black, Funer Armed Forces? White etc Never Married 2 X No Yes 3 X Widowed 1 Yes 2 X No specify. Black 4 Divorced If Yes, Give Year Specify à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 3altimore, MD 21215-0036 Housewife Private 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) permit Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, the Minnie Hall Theodore Strothers 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Barnsbury Court, Capitol Heights, MD 20743 Doreen Dorsey (Daughter) 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition 20c. Location - City or Town, State crematory or other place)
Quantico Nat 1 1 X Burial 2 Cremation 3 Removal from State Cemetery 1/18/07 Triangle, VA Donation 5 Other Specify. Signature of Funeral Service Licensee 22. Name and Address of Facilit 5538 Marlboro Pike Pope Funeral Homes, P.A., Forestville, MD 20747 1 190105 Par II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Chronic obstructive pulmonary disease complicating congestive heart Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Hypertensive cardiovascular disease Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Physician/Medical X UNPENDED g physician the burial -AMENDED #23a-b,PII,27,perME, G864, 2/2/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? attending por use as the Live birth Fetal death Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 V Unknown Renal failure, obesity, sleep apnea 24a Was an 24b. Were autopsy findings available prior to completion of cause of autoosy this certificate has performed death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other<sub>4</sub> Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene 1 🗸 Yes Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: n 24 hours after dea.... In Euneral Director: After a fu 1 X Natural 5 Pending Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) \_0 and manner stated 29b Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. January 12, 2007 30. Name and address of person who completed cause of death (Item 23a)

Registrar

DHIVIT 17 REV 1/2001 **OCMF 2006** 

State

Tasha Greenberg MD.

IAN 2 2

31. Date filed (Month, Day, Year)

istrar's Signature

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Registrar

31. Date filed (Month, Day, Year)

medis

32. Registrar's Signature

07-00299 Roger Foster

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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212 212 ould be Menta mark	To Be	19a Informant's Name/Relationship			19b. Mailing A	uddress (Stre	et and Number	or Rural Route Nur	mber, City or Town		Code)
2 sh an 27 i 27 i		Valeria Foster-m	other		606 W	Frank	lin St.	Apt. 2 E	Baltimore	e, MD	21201
Baltimore, Normit. Pages I and Department of Health Important: If item		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from Sta	u. cr	ace of Dispositi ematory or othe	r place)		Date	20c. Location -	,	
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Division of Vital Records, tal or Attending Physician: The law requirers after death  In Director: After this certificate has been sited in by the funeral director, page 2 should the sounders of the funeral director, page 2 should the funeral director.	٦.	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Inju	ry :	R/Outpatient 28b. Time of Inji	L	ury at Work?	rsing Home 5	Residence 6 v		ne 
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only   Certifying Priys	sician: To the best of mer: On the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of								use(s)
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		30. Name and address of person who	,			Street D-1	timora MAD	21201	1		
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Registrar DHMH 17 Rev 1/2001

State

Christopher
31. Date filed (Month, Day, Year)

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2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 5:55 Frank Marcus Fonte January 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Health & Rehab Anne Arundel Glen Burnie 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 k M 2 □ F Days Hours Min. May 18, Director 65 1941 Maryland 214-38-1548 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notifled at Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA Funeral 300 Roosevelt Avenue 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. δ 3 Widowed 4 Divorced "natural". Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Produce Manager</u> Grocery Store other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n 27 is marked er traumatic e Luber Joseph Fonte Helen ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra F. Diggs (Daughter) 300 Roosevelt Avenue, Glen Burnie, MD 21061 Department of Health Important: If Item 27 any Injury or other tr once. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 1/19/07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 №No certificate has b irector, page 2 sl 24a. Was an autopsy 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. within 2 the 29b. Signature and title of reptile 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sw Glin Burnic MI Grain ieet

Registrar's Signature

**ORIGINAL** 

DHMH 17 Rev 1/2001

State Registrar George Forbes, III

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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DHIVIN 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2007  $p^M$ Gruss Francis January 3:45 Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Dulaney Valley Baltimore 8. Date of Birth (Month, Day, Year Dec. 26, 1 if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 2 M 2 □ F 217-16-3790 Ĩ923 83 Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔼 No Completed by Funeral Director Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3365 N. Chatham Road, Apt. A 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2K Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Funeral Director Funeral Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kar1 Gruss Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3365 N. Chatham Rd., Apt. A, Ellicott City, MD 21042 Bessie E. Gruss (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 1/22/07 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Paul Efficer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. il Director: After i 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State JAN 2 2 2007 Registrar DHMH 17 Rev 1/2001

**Physician** 

/Medical

Examiner

Baltimore **Funeral** 1 □ M 2 📈 F 213-39-2595 78 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show Funeral Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code ns 23a or 7 must be n 21208 16 OLD COURT ROAD #611 er than "natural", or Items, the Medical Examiner mi 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER 17. Father's Name (First, Middle, Last) Maryland Be ould be fi Mental F GALPERIN URI DINA မ atient Known 19a. Informant's Name/Relationship (Type. Print) LEV GABRIYELOV / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM 101/19/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligense 23a. Part1. If ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, if hear failure. List only he cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examine mphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1. Yes 2 No
9 N Unknown 5 ☐ Other (specify) signed by the a d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a, Was an page 2 s certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2**X** No 2 1 ☐ Yes 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 □ Yes 2 □ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.O. 32. Registrar's Signature 31. Date filed (Month, Day, State

1. Decedent's Name (First, Middle, Last)

KLARA

4a. Facility Name (If not institution, give street and number)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Day GABRIYELOVA 07:10AM Januar 2007 4b. City, Town, or Location of Death 4c. County of Death altimore N/A If Under 24 Hrs. 8. Date of Birth Mours Min. 03/08/1928 Birthplace (State or Foreign Country)
 RUSSIA 10d. Inside City Limits 1 ☐ Yes 2 🙀 No 10g. Citizen of What Country? USA 14 Bace - American Indian Black, White, etc. WHITE Specify: 16b. Kind of Business/Industry EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 OLD COURT ROAD #611 - BALTIMORE, MD 21208 20c. Location - City or Town, State REISTERSTOWN, MD SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

mon 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

w

J-Clientes

2

JAN 2

6701 N. Charles

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18 per 1h 9863 1-22-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 621 AN ATOYA HARVEY JAN 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard C. General Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 6–11–1978 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 071-62-0719 Yrs. **Director** 28 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at Md. Howard Columbia 1 ☐ Yes 2X No Director 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 5180 Brookway 21044 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2X No f Yes, Give 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŒNo Black Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled NA 12th grade 18. Mother's Name (Thomason 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be if Health and Mental Harvey, Jr. Leroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Harvey 5180 Brookway, Columbia, Md. Mother 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō = 6 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or Good Sheppard Cem. 1-20-07 Ellicott City, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave., Baltimore, Md. 21202 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ROSPIRATORY DISTRUSS SYNDROME 2 0445 resulting in death) /Medical Due to (or as a consequence of): Examiner PNEYmonia DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed SOPTIC burial-transit DAYS SITULIK and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician PRABOR 2545ARS Physician/Medical SYNDRUME WILLI as the use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) detached ☐Yes 2☐No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 No 2 No 1 Yes Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter or Attending 5 Pending Injury 1 Natural 1 Yes 2 No death 2 Accident investigation within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Tot 036974 im 17 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21544 O. NYMITEM 12724 LITTLE PATURENT PARKWAY MUD Corumbia

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Gordon Van Hor		1- For State	of Maryland / Der C	partment d ertificate d		na Mental F			107 0124			
Physicia		Registrar 1. Decedent's Name (First, Middle,Las					2. Date of De Month		3 Time of Death			
Medical Exami		Gordon	Van	Horton  4b. City, Town, or Location of Death			January		2045 NIS			
		4a Facility Name (if not institution, giv- Maryland General Hospita		Baltimore	r Location of Dea	tr1	4c. County of Death					
Funeral Director		5. Social Security Number 6. Security Number 16. Security Number 17. Security Number 16. Security Number 1		s. (ast birthday)	If Under 1 Ye		_		9 Birthplace (State or Foreign			
Director		Usual Residence of Decedent	M 2 F 3:	5 <sub>Y</sub>	Yrs.			-24–1973	Country) Philda.			
v any		10a State 10b. County	10c. C	ity, Town or Loc	ation				10d Inside City Limits			
land f show	ğ		NA	Balt	imore				1 X Yes 2 No			
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene flumportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner, must be notified at once.	Director	10e. Street and Number 2133 W. Mulberry	Street		10f. Zip Code 212	23		10g Citizen of Wha				
h with ems 23.	Funeral	11. Marital Status  1 Never Married 2 X Married	12. Was Decedent Ever in Armed Forces?	16	Vas Decedent of H Yes, specify Cuba			o- 14 Race - White,	American Indian, Black,			
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21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	Be	Leve	E.	Horton Pauline 19b Mailing Address (Street and Number or Rur.				_				
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re, N I and Thealth friem er frau		20a. Method of Disposition  1 X Burial 2 Cremation 3	20	b. Place of Disporter	osition (Name of cother place)		Date		City or Town, State			
Baltimore, permit Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify			cmel Cem		-19–07		lk, Md.			
Balt permit Depart Impor		21. Signature of Funeral Service Licen	Waner		Name and Addre	ss of Facility I' North Ave	Barch F. Balt	H. East imore, Mo	d. 21202			
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the dea	ath. Do not enter	the mode of dying	g, such as cardiac	or respiratory a	rrest, shock, or hea	rt Approximate Interval Between Onset and			
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	Examiner	identify any, leading to immediate Due to (or as a consequence of):    Consequence of the consequence of the										
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be executed ician and urial - transi	cian/Medical	UNPENDED										
876C lificate ng phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr		Fetal death 3	Ectopic preg	nancy	23d. Date of o	delivery Day Year			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physiciane relative tory, page 2 should be detached for use as the bur	S	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time of 9 Unknown	death	Other (Specify)		,					
O, Bo t the de by the ached f	Phy	Part II. Other significant conditions	contributing to death but no	ot resulting in the	e underlying cause	given in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?			
, P.O. ires that the signed by	d by						1 Y	es 2 🗸 No 3	Probably 4 Unknown			
ords Iw requ as been	ompleted							opsy pr	/ere autopsy findings available rior to completion of cause of			
Rec The 1st icate h	Com						1 🗸 Yes		eath?  Yes 2 No			
Vital Rec system: The his certificate director, page	Be	25 Was case referred to medical examiner?	lospital: 1 Inpatient 2	✓ ER/Outpatie		Other Nurs	k only one) sing Home 5	Residence 6	Other:			
of V g Phys fter thi	: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b Time o		jury at Work?	28d Describe	how injury occurre	ed .			
sion trendir death stor: A	ation	1 Natural 5 Pending 2 ✓ Accident Investigat		1941 hrs	1	Yes 2 V No	Passenger	auto auto coll	ISION			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ertification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway 286. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Log Route						f. Location (Street and Number or Rural Route Number, City or Town, State) ute 40 (by-Pass)& Arlington Ave, Baltimore, MD				
Hospi 24 hour Funer stely fill	Ç	29a Certifier 1 Certifying Physic	ian: To the best of my know	ledge, death occ	curred at the time,		nd due to the car	use(s) and manner	as stated			
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated										
	2	29b Signature and title of certifier	MUX		29c License number O.C.M.E.				29d Date signed (Month, Day, Year)  January 13, 2007			
		30. Name and address of person who						1				
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32. Registrar's Signature										
Regis	tate trar	JAN 2, 2 20		S. 190	- Complete			·				

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			For State Registrar	State of M	laryland		rtment of H	lealth an	d Mental		711111	01250	
ę.	Physici	_	1. Decedent's Name (First, Middle, Foster)	Can1+	on		lett	-57	2. Date Mont	of Death	2 0 4 3 7	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Carroll Hosptial Center				4b. City, Town, or Westmins	ter			4c. County of Death Carroll		
tin.	Funeral Director		5. Social Security Number 214-32-7688 Usual Residence of Decedent	6. Sex 7. A	90 (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mon	of Birth th, Day, Ye 0/1936	ar) Col	pplace (State or Foreign intry) Land	
ith the Maryland or 28a-f show		ctor	10a. State 10b. County  Maryland Carrol	.1	10c. City, 1 Westn	own or Lo				E		10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
<b>5-UUSO</b> 72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show	vith th	Funeral Directo	10e. Street and Number				10f. Zip Code				Citizen of What Cor	•	
	eath v	erai	1805 Bllom Rd.	12. Was Deceden	t Ever in LLS	13 V	21157	ispanic Origin	2 (Specify Ves		Jnited Sta		
	hours after d tural', or item al Exeminal	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces	? ] No		Vas Decedent of Hi Yes, specify Cuba	n, Mexican, P	uerto Rican, et	c.)	Black, White	, etc.	
0-6121	J within 72 hours after death with the Maryla liens than "natural", or iteme 23s or 28s-1 shov the Medical Examinat must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or	5+)	(Give life. [	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of )	working		. Kind of Business/I		
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Z	alth an 27 is rrteu	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  Connie Miller (Miller)  617 Fern Way Sykesville, DM 21784										p C006)	
ore,	ges 1 end 2 should t of Health and Mer if itsm 27 is marke or other treumatic		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3	•	20b. Plac	e of Dispos	sition (Name of natory or other place		Date		Location - City or 1	own, State	
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	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a Electromechanica dissociation Zomin									
	Examiner		Sequentially list conditions	ISC	hem	10	Car	dio	MYO	pat	hy	Syrs	
Ī	be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequer								
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O. BOX C	uires that the death certificate signed by the attending phys d be deteched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown				23d. Date of delivery Month Day Year						
cords, r	law requires that the as been signed by th 2 should be deteche	by	Pair it. Other significant conditions controduing to death out not resulting in the underlying cause given in Part I.							Did tobacc	the cause of death?		
T E	The hate had age	Completed								Was an autopsy performed	ppsy prior to completion of cause of		
VII	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 PNo	Hospital:	art of		Othe		Death (Check				
0	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inj	ury 28	b. Time of	28c. Injury Work	4   Nursir			6 □Other (Spec	<u>(fy)</u>	
0 00	r Attending P er death. irector: Alter t s by the funera	catio	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident Investigation C ☐ Could get be										
	spital or Att ours efter d leral Direct filled in by 1	Certification:											
	To the Hospital within 24 hours e To the Funeral I completely filled	Medical	one)	Physician: To the bes xaminer: On the basis and manner s	of examination	dge, death and/or inv	occurred at the timestigation, in my op	ne, date and p pinion, death o	lace, and due to occurred at the	time, date	and place, and due	to the cause(s)	
1	To the Comple	2	29b. Signature and title of certifier  Pobert 16	Pickets	MDO	ms	29c. License	929	76		Date Agned (Month)	( Day, Year)	
8	ı		30. Name and address of person w RICITE/S 31. Date filed (Month, Day, Year)  JAN 2 2	no completed cause of	death (Item 23	Ba) (Type, I	estmir	15 te	1 m	0	2115	>	
0.000	Sta Registr		31. Date filed (Month, Day, Year)	2007 32, Hegist	trar's Signatur	A	uli						
			Military			-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Steven Thomas Haley 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 14, 2007 1248 hrs Medical Examiner Steven Thomas Haley 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) 4c. County of Death Owings Mills **Baltimore County** 2 Bridgeport Court Apartment 103 If Under 1 Year If Under 24Hrs 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Months Davs Hours Foreign Director Country 1 XM 32 MD 212-82-4167 March 25. Usual Residence of Deceden 10d Inside City Limits 10b Count 10c. City. Town or Location Yes 2 X No 28a-f show s 23a or 28a-f sho MD Baltimore Owings Mills after death with the Maryland rector 10f. Zip Code 10g Citizen of What Country 10e Street and Number 21117 U.S.A. 2 Brightview Court Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status must be Armed Forces? White, etc. 1 X Never Married Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify. Widowed White ð 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical other than Baltimore, MD 21215-0036 t Pages I and 2 should be filed within tment of Health and Mental Hygiene rtant: If item 27 is marked other than 2 Years Manager Restaurant Comi 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Eldridge Haley, Jr. Sharron Dukes 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) White Willow Court Owings Mills, MD 21117 Sharron Illian<u>o</u> Mother Date 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State or other Burial 2 X Cremation 3 Removal from State 1/16/07 Carroll Cremation Ser. Hampstead, MD Donation 5 Other Specify 22 Name and Address of Facility 11824 Reisterstown Road 21 Signature of Funeral Service Licensee allen ELINE FUNERAL HOME Reisterstown, MD 21136 Approximate Interva Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure List only one cause on each line /Medical Death Narcotic intoxication (heroin) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and g X UNPENDED AMENDED #23a,27,28a-f, perME, g863, 1/29/07 TT The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE phy the 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? <u>о</u>

Physician/Medi þ Completed Be After Certification: within 24 hours a To the Funeral E

2

3

29b.

Suicide

Homicide 29a. Certifier

Signature and title of certifie

Division of Vital Records,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

25 Was case referred to medical Hospital: 1 Inpatient 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural Pending Accident Investigation

6 X Could not be determined House (Specify)

and manner stated

28b. Time of Injury FNd 1/14/2007 28e. Place of Injury - At home, farm, street, factory, office building, etc

Fnd 12:30 pn

DOA

Yes 2 X No

Other<sub>4</sub>

28c. Injury at Work?

29c. License numbe

O.C.M.E.

26.Place of Death (Check only one)

28d Describe how injury occurred unknown 28f Location (Street and Number or Rural Route Number, City or Town, State) 2 Bridgeport Ct. Apt 103 Owings Mills, MD

death? 1 🗸 Yes

1 Yes 2 V No 3 Probably 4

24b. Were autopsy findings available

prior to completion of cause of

2 No

24a Was an

autopsy

✓ Yes 2

performed?

No

Nursing Home 5 Residence 6 ✔ Other Scene

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year)

January 15, 2007

Unjune 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Margarita Korell MD.

2007

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month Pey State Registrar

Medical

32. Registrar's Signature

ER/Outpatient 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JANUARY 17, 2007 **HADDAD** 11:12 A M RUFA GOLD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE OWINGS MILLS 8914 GROFFS MILL DRIVE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9/1/1938 Birthplace (State or Foreign Country)
 T **Funeral** IL 68 098-32-7393 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No Director OWINGS MILLS MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? De e 21117 USA 8914 GROFFS MILL DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11: Maritai Status 1 Never Married 2 Married 0 WHITE 1 ☐ Yes 2 X No Completed by Specify 3 ☐ Widowed 4 N Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **TEACHER EDUCATION** 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GOLD ROSE SIMON ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra 11121 HIDDEN TRAIL DRIVE - OWINGS MILLS, MD 21117 ELLIOTT GOLD / BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/19/2007 OWINGS MILLS, MD HAR SINAL CEMETERY 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) BREAST CAIVE **Physician** 12 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-tran-Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has rector, page 2 perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 ☐Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? (Month, Day 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death.

I Director: A in by the fu

Baltimore, Maryland 21215-0036

within 24 hours aft To the Funeral Di completely filled in 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1-17-07 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who alls 1075 Û 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2007 Registrar DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylar		artment rtificate			nd M			nn.	7	0125	13
			Decedent's Name (First, Middle	, Last)			- Intocate	0. 2	Journ	-	2. Date of Dea	th	_ 0 0	1	3. Time of Dea	ath
	Physicia		Hans Pete	r Illi	o						Month January	Day 1 R		ar	3:55 P	М
	/Medic Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location of		January		County of D	Death	3.33 1	
		Ť	Fairfield Nurs	ing Cent	er		Cr	owns	sville	2			Anne	Ar	unde1	
Ē	Funeral		5. Sociaf Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs.	8. Date of Birtl (Month, Day	Year	9.	Birthpl	ace (State or Fo	oreign
	Director		406-64-2734_	1 X M 2 ☐ F	62	Yrs.	Months	Days	nouis	IVIII I.	Aug 11	, 19	44		many	
	D		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ly. Town or Lo	cation								d. fnside City Li	imito
	ehor ehor	ក			100.01									10	11∑TYes 2[	
	the N	Director	Maryland Anne  10e. Street and Number	Arundel		Ode	enton	Code				10- 016			21	
	a or	គ			101		10f. Zip					-	zen of What			
	eeth	Funeral	2604 Clarion (		cedent Ever in U	S 13 1		21113		in? (Sne	city Yes or No-		Unite			
_	fler d	F	1 ☐ Never Married 2 ☑ Marr	Armed I	Forces?		If Yes, spec	ofy Cuba	n, Mexican,	Puerto I	cify Yes or No- Rican, etc.)		Black, V			
3	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, C Year or	Sive		1 ☐ Yes 2	2 <b>∏</b> No	Specify:				Specify:	Wh	ite	
5	2 ho	Completed	15. Deceden		-0	16a. Dece	dent's Usua	i Occupa	ition			16b. Kir	nd of Busine			
<u>'</u>	Mad Mad	pie	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	Deputy	kind of wor DO NOT us	a retired	1		ng					
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2	be lied within 72 hours after deeth with the Maryland Hygiene. Hygiene. All Hygiene. A control then "natural", or items 23s or 28s-f ehow do other then "natural", or items 23s or 28s-f ehow event, the Madical Examiner must be notified at	Be (	17. Father's Name (First, Middle,	Last)					18. Mother	's Name	(First, Middle,	Maiden	Sumame)			
<u>x</u>	Men Men arke atic	ပ္	Karl Friedri		ig					ilde			Eberh			
<u>a</u>	2 sh and iem	l	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	ind Number	r or Rura	Route Numbe	r, City o	Town, Star	te, Zip	Code)	
≤ 15	end fealth m 27 her to		Lien Bich Illig	g/wife	201				Court						and 211	13_
2	if ite		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from	m State	Place of Dispo cemetery, crer	matory or of	ther place	· 1		ate		cation - City			
	tmen tent:		4 Donation 5 Other (S		We	st Arur			1-		_				ryland	
0	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if time 27 is marked other then "natural; or ttems 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee		22 I	onald	d Addres ISON	Fune i	ra1 1	Home &	Crem	atory	, P	.A.	
_	40.204		Hierotti Ox	Thomas					the state of the s		dodent	-	Maryl	and		
			23a. Part . Enter the disease, or shock, or heart failure. List	only one cause or	n each line.	in. Do not ent	er the mode	e or ayıng	g, such as c	ardiac o	r respiratory an	rest,			Approximate Interval Betwee Onset and Deat	
	Physician /Medical	123	fmmediate Cause (Final disaase or condition resulting in death)	_ a //3	piration	n pn	MM	me	4							
	Examiner			Due y	o (or as a consec	quence of):	/									
		ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	O (pr as a conse	Wence of	/									
	nted Insit	u u	cause. Enter Underlying Cause (Disease or injury that initiated events	(	,											
	exect n end iai-tra	Examiner	resulting in death) Last	C. Due to	o (or as a consec	quence of):										
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0	tificat ig phy as th															
Š	n cer endin	<u>S</u>	fF FEMALE: 23b. Was decedent pregnant		outcome of pregna		∃Ectopic pre					2	3d. Date of	defive	у	
	deat	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of c		Other (spe						Month		Day Year	1
י כ	The law requires that the death certifi sie has been signed by the ettending f page 2 should be detached for use as	Physician/M	9 Unknown													
ກົ	tree de	b	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying ca	ause give	n in Part I.						e causa of death	
coras	seen s	Completed									1 🗆 Y	es 2	2No 3□	] Proba	ıbly 4 ∏Unkr	iown
ပ်	law las b	pie									24a. Was a		24b. Were	autop	sy findings avai	ilabfe e of
		ပ္ပ									perfor 1 ☐ Yes	med?	deat	h?	2E No	
<u>a</u>	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?							of Death	Check only or	7e/				
5	hysi this c	မ	1 ☐ Yes 2 ☐ №6			ER/Outpatier			4 E HVUI		ne 5 🗆 Resid			Specify	)	
	ing F	ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	g (Mo	te of Injury onth, Day Year)	28b. Time of Injury		8c. Injury Work			8d. Describe h	ow infun	occurred			
SION	Attending ir death. ector: After by the fune	cat	2 Accident investig	not be			М		/es 2□N		105.1			-		
	or Al after Direct in by	Certification:	4 Homicide determ	ined 286. Pla	ce of Injury - At h Iding, etc. <i>(Speci</i>	ome, tarm, str fy)	eet, factory	, office		2	City or Tow	n, State)	Number o	r Hurai	Route Number,	
	To the Hospital or Attending Physicien: within 24 hours state death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifyin	g Physician: To t	he best of my kny	owledne desti	h occurred :	at the tim	e date and	I nlace o	nd due to the o	auca/s\	and menns	r ae ot-	tad	_
	e Ho 24 h Fur etely	edicai	(Check only 2 Medical one)	Examiner: On the	basis of examina	ation and/or in	vestigation,	in my op	ninion, death	h occurre	ed at the time, o	late and	place, and	due to	the cause(s)	
	Nithin Fo th	₩	29b. Signature and title of certifie				29c	. License	number		2	29d. Date	e signed (M	lonth, £	Day, Year)	
				γλ,			i	28	958	-		1/1	9/07	,		
, fx	X		30. Name and address of person	no completed ca	use of death (Iter	m 23a) (Type,	Print)	- 0	, - 0			-1	. /			
10	d		Du lest &	nuch S	colley o	208 Cr	am !	4colo	1200	Sa	Ofen	Buy	nu o	40	21061	
	Sta		31. Date filed (Month, Day, Year).	32.	Registrar's Signa	ature	*		7		-					
	Registr	1	IAMA A	0007		All a	Camara Al	E .	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10/125001 MYRDIS henuar 10. 2007 /Medical 4a. Facility Name (If not institutioղ, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMURE MD 91223 Secars if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08 31 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M X F 87 19 SC Director 217-18-5759 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show at Examiner must be notified 1X Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 5146 Stafford Road Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: δ 3 X Widowed 4 ☐ Divorced the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Nursing Aide German Age Home item 27 is marked other other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Coleman Lettie Moody 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau once. 21215 5325 Maple Ave, Baltimore, Md Carl Johnson-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn 1/17/07 Baltimore Co, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee March F/H West M 4300 Wabash Ave, Baltimore, 21215 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypotension, CARDIAL ARREST Physician . /Medical Due to (or as a consequence of): Examiner 11aun Stenos? if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) 9 Unknown ed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Dustomi Collagen Vagular despesse 1 | Yes 2 | No 3 | Probably \*↓ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate SPSTruc /p / 1 Yes 21X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 □ No within 24 hours after deaun.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ္ခ way 000170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000.W. BAL Janore II 31. Date filed (Month, Day, Registrar's Signature State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p

Registrar

State

29b. Signature and tiple of

31. Date filed (Month, Day, Year)

MAHESHWARI

JAN 2 2

MD

NORTHWEST

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2 Medical Examiner: Op-the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) JAN 13, 2007

RANDALLSTOWN. MD

			1 - For State Registrar	State of Marylar	nd / Departm		ealth and M	ental Hygi	ene2 0 0 7	01256
	Physici /Medi		1. Decedent's Name (First, Middle, Las	JOBS				2. Date of Death Month	Day 2007	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give	ucal lew	last birthday) If U	Paul F	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of Deat	h hplace (State or Foreign untry)
	Director		216-62-1359  Usual Residence of Decedent  10a. State 10b. County	49	Yrs.		Name:	2/17/195	7 Mar	yland  10d. Inside City Limits
4 0 4 0 4 0	Militie Malyian Sa or 28s-f show	Irector	Maryland Baltimo:	re Ess		. Zip Code		109	g. Citizen of What Co	1 ☐ Yes 2 🛣 No untry?
5-0036	rel', or iteme 23a Examiner must b	by Funeral Director	322 Stemmers Run  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Road  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 20 No If Yes, Give Year or Dates:	.S. 13. Was D If Yes,	21221 ecedent of His specify Cuban s 2 [KNo	spanic Origin? (Spe , Mexican, Puerto I Specify:		14. Race - Ame Black, White	
21215-0036	- 49	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Decedent's (Give kind o life. DO NO	Jsual Occupat f work done du T use retired)	iring most of workii	ng 16	6b. Kind of Business/l	
and 21	ntal Hygi od other event, I	Be Con	17. Father's Name (First, Middle, Last)  Benito JaMart	2	Contract		18. Mother's Name	(First, Middle, Ma	elecommun:	ications
Maryland	h and h and l	은	Benito IaMart.  19a. Informant's Name/Relationship (7)  Clyde E. Jobe, Jr	ype, Print)	19b. Mailing Add			Freed Route Number, C Maryla	City or Town, State, Z	ip Code)
Baltimore,	nent of Heelt int: If Item 2: iry or other	Ì	20a. Method of Disposition  1	Removal from State	Place of Disposition cometery, crematory	Name of or other place	D	23 20	altimore	
Balti	Department Important: If any njury or once.		21. Signature of Funeral Service Licen		22. Nam Bruz	and Address	of Facility i Funeral	Home PA	sex, Mary	
	hysician /Medical xaminer	-	23a. Part 1. Enter the disea of companies of companies of condition resulting in death)  Sequentially list conditions.	a. Due to (or as a conseq	h. Do not enter the control of the c	mode of dying,  U  WH	such as cardiac or lavabi age	respiratory arres	t,	Approximate Interval Between Onset and Death > 2 0 0 3
8760,	2 2	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			,			
P.O. Box 68	ed by the ettending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	I death 3 Ectopi	c pregnancy (specify)			23d. Date of dein Month	very Day Year
	been signed I	۾	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the underlyin	ig cause given	in Part I.		cco use contribute to	the cause of death?
I Rec	ate hes b	Completed	Y1810°	1				24a. Was an autopsy performe 12 Yes 2	d? prior to co	opsy findings available ompletion of cause of
of Vita	r this certifice ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2  Yes	Hospital:	ER/Outpatient 3□	DOA Other	26. Place of Death		ce 6 □Other (Spec	fu)
0 00	2 2		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		8d. Describe how		·//
Division	within 24 hours after death.  To the Funeral Director; A completely filled in by the fu	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fac			8f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	n 24 hours he Funeral oletely fille	edical C	29a. Certifier 1 certifying Ph (Check only one) 2 Medical Exam	sician: To the best of my kn. iner: On the basis of examinal and manner stated.	wledge death occur tion and/or investigal	red at the time tion, in my opin	, date and place, a nion, death occurre	nd due to the caug d at the time, date	and place, and due to	stated. o the cause(s)
John	Toth	Σ	29b. Signature and title of certifier	COUD A	rteudiu	29c. License i	5639°	1 8	Date signed (Month)	Day, Year)
j	U		30. Name in address of person with a	ompleted cause of death (Item	23a) (Type, Print)	301	ST. Pau	11 81.		
	Şta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture Roself					

			For State of N Registrar	/laryland /		ment of Hi Ficate of I	lealth and Me D <i>eath</i>	ntal Hygien Reg. N	2001	01257
	Physici	an	Decedent's Name (First, Middle, Last)				2	Date of Death Month	av Year	3. Time of Death
X.	/Medio		Edith A. Johnson  4a. Facility Name (If not institution, give street and number	nr)	4	b. City, Town, or	Location of Death		c. County of Deal	11.1.1
	Funeral Director		Pel A le Leouth	Age (In yrs. last t		Under 1 Year fonths Days	If Under 24 Hrs. 8 Hours Min. A	Date of Birth (Month, Day, Year	10000 917 Of	hplace (State or Foreign
	ס		Usual Residence of Decedent  10a, State  10b. County	100 City To						Land Inside City Units
	Maryla f shov	tor	Maryland Harford	10c. City, To	Air	ion				10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23s or 28s	ai Director	10e. Street and Number 410 East MacPhail Rd.			10f. Zip Code 21014	1		itizen of What Co	L ountry?
980	72 hours after death with the Maryland naturel', or items 23s or 28s-1 show dissal Examinal must be redified at	by Funerai	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 HYes, Give <sup>2</sup> 3 Widowed 4 Divorced	s? ⊡No	If Y	s Decedent of Hes, specify Cuba	ispanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	within ane. then	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)	or 5+)	(Give kın life. DO	NOT use retired	furing most of working )		Kind of Business/	
d 2	Il Hygie other	Be Co	8 17. Father's Name (First, Middle, Last)	1	Kenta	al Ager	18. Mother's Name (		eal Est n <i>Sumame</i> )	_ale
Maryland	ould be i Mental I Marked o	To B	Anthony Stavana				Mary	Zolar		
Man	12 should be and Ment 7 is marked traumatic	1.3		on-			and Number or Rural F		or Town, State, 2	Zip Code)
Baltimore, I	Pages 1 and 2 nent of Health int: If item 27 inty or other tra		Robert H. McGraw — in  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from Sta  4 □ Donation 5 □ Other (Specify)	20b. Place cemen	of Disposition of Dis	Miller on (Name of ory or other place Cem. C		9 20c. l	d. 2115 Location - City or odlawn ,	Town, State
Baltir	permit. Pages Department of Important: If i any injury or once.		21. Signature of Jin at Seprice Licensee		22. N	ame and Addres	ss of Facility Eckh	ardt Fu	neral (	Chapel P.A.
W. W.	Physician /Medical Examiner	Examiner	Sequentially list conditions.	as a consequence	ce of):	he mode of dyin		espiratory arrest,		Approximate Interval Between Onset and Death
68760,	ficate be executed physicien and s the burial-transit	edical Exar	that initiated events c.	as a consequenc	ce of):					
P.O. Box (	death certif e attending id for use a	Physician/Me		2 Fetal dea at time of death		topic pregnancy ther (specify)			23d. Date of del Month	ivery Day Year
	law requires that the de es been signed by the a 2 should be detached f	by	Part II. Other significant conditions contributing to death	ı but not resulting	g in the unde	rlying cause give	en in Part I.		1-	the cause of death?
of Vital Records,	The ate h page	Completed						24a. Was an autopsy performed? 1 Yes 2 N	prior to death?	atopsy findings available completion of cause of 2 ☐ No
<u>X</u>		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 1 No Hospital: 1 ☐ Inpa	atient 2 ☐ ER/0	Outpatient	3□ DOA Oth	26. Place of Death N	Check only one.  5 ☐ Residence	6 DOther (Spe	cifu)
n o	ng Phys fter this ineral di	on: T	27. Manner of Death  1   Natural 5 □ Pending (Month, I		Time of Injury	28c. Injun Worl		d. Describe how inju		3.97
Division	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	fn <sub>f</sub> ury - At home, etc. (Specify)	farm, street		Yes 2 □ No 28	Location (Street a City or Town, Stat	ınd Number or Ru te)	iral Route Number,
	ne Hospital n 24 hours ne Funeral I	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the be selected by Medical Examiner: On the basis and manner	st of my knowled; of examination; stated.	lge, death or and/or inves	curred at the tin tigation, in my o	e, date and place, and pinion, death occurred	d due to the cause(s at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the I	Me	29b. Signature and title of certifier	D		D3	number YESZ	29d. D.	ate signed (Month	stated. to the cause(s)  h. Day, Year)  9, 2007
	N		30. Name and address of person who completed cause of \$1.011 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	North	a) (Type, Pri	nt)	Bil Air	mury lu	vd 21	014
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regi	siais signature	Cons	وع		/		

DHMH 17 Rev 1/2001

State Registrar FALLS

3730

BALTIMORE

ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ULA71

M.D

32. Registrar's Signature

BOHIT

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Ma	arylan			nt of H te of L				Reg. No.	007	01259
	Physici /Medic		1. Decedent's Name <i>(First, Middle, La</i> Viola	st)		Ken	nedy				2. Date of De Month		200 <sup>Y</sup> gar	3. Time of Death 6:a M
	Examin		4a. Facility Name (If not institution, giv Loien Frankford				4b. City	, Town, or Bal	Location of			. 1	unty of Deeth NA	1
	Funeral Director		5. Social Security Number 6. S 251–68–8582  Usual Residence of Decedent	ex 2 F 7. Ag	91 (In yrs.	last birthday) Yrs.	If Unda Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da 12-1	5–1915	9. Birth Cou	pplace (State or Foreign shirty) S.C.
	anyland ahow	J.	10a. State 10b. County		l	y, Town or Lo Baltim								10d. Inside City Limits 1 X Yes 2 □ No
	ith the Marylar or 28a-f ahow	Funeral Director	10e. Street and Number					p Code	010			10g. Citizer US	n of What Co	
	ns 23a	eral	2333 E. Oliver	12. Was Decedent	Ever in U	.S. 13.	Was Dece		213 spanic Ori	igin? (Spec	cify Yes or No lican, etc.)		Race - Amer	
9800	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f ahow cdical Examiner mast ke notified at	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ♣ If Yes, Give Year or Dates:	No.		If Yes, spe 1 ☐ Yes		Specify:		lican, etc.)		Black, White	
21215-0036		Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 7th grade		i+)		dent's Usu kind of w DO NOT I	ork done d use retired	ition <i>luring</i> mos )	t of workin	g		of Business/l	ole Home
Maryland 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic avent, II a Manace.	To Be C	17. Father's Name (First, Middle, Last Charles	)	J	ohnson	1			er's Name Katie	(First, Middle,	, Maiden Su Ru	mame) ussell	
	alth and 27 is mu		19e. Informant's Name/Relationship ( Viola Hopkins	Type, Print) Daughter							, Balt			ip Code) 21213
Baltimore,	Pages 1 anneal of He ant: if item arry or othe		20a. Method of Disposition 1 □ Urial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Special		ion-City or I									
Balt	permit. Departr Imports eny inji		21. Signature of Funeral Service Lice	arch F Balti			21202							
8760,	Physician produced by Medical Example produced Example produced by Medical Production of the pright produced by Medical Production of the pright produced by Medical Production of the produced by Medical Production of the product	Physician/Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death									
O. Box 6	that the death certifica led by the attending ph detached for use as th	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Il death 3	∃Ectopic p ∃ Other (s					23d	l. Date of deliment	very Day Year
ds, P	90 90	by	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying	cause give	n in Part I			obacco use Yes 2□N		the cause of death?
Il Records,	The taw ate has b page 2 st	Completed									24a. Was autor perfo 1 🗆 Yes	osy rmed?	oprior to c death?	opsy findings available ompletion of cause of
Vital	Physician: The this certificate ral director, page	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatier	nt 3□ D	OA Othe	or /		(Check only o		Other (Spec	ifu)
on of	fer		1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Heside											.,,,
Division	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	lumber or Ru	ral Route Number,									
	24 hour Funer stely fills	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa-	nysician: To the best niner: On the basis of and manner sta	examina	wledge, deat ition and/or in	h occurred vestigation	at the tim	e, date ar pinion, dea	nd place, a oth occurre	nd due to the d at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier				29	c. License	number			29d. Date s	igned (Month	, Day, Year)
	39		30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type.	Print	DYE	<del>)</del> 7-7	-+		111	107	4.000.000
_			31. Date filed (Month, Day, Year)	Bhar	RVS	- 6	26	1/	NU	1/0	wen	Kin	2 1	M1)2/25
	Sta Registi		1. Date filed (Month, Day, Fear)	32. Registr	a s sign	S. S. S. S. S. S. S. S. S. S. S. S. S. S	-0.2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #31, perDVR, 683, 1/22/07 TT Continue to Great Amend #31, perDVR, 683, 1/22/07 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** P2007 1:50 JANUARY 21 **GREGORY** KAISER ALAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours **XX**M 2 □ F 213-60-8150 55 Jan 18, 1952 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Carroll Taney town MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with United States 21787 211 Roth Ave. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1000 Pes 2 No 1969 − If Yes, Give Year or Dates: 1970 1 Never Married Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2♥ No Specify: Completed by 3 Widowed 4 Divorced 1970 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) City of al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Frederick Assitant Water &Treatment Plant 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental ! 7 is marked of Ruth T. Weller Robert H, Kaiser ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 211 Roth Ave. Taneytown, MD 21787 of Health item 27 i <u> Iva Kaiser (wif</u>e) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem Gardens 1/26/2007 Finksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximations described by the such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 15 Chemia MYUCARDIAL Physician MOVVS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by chexia 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? certificate 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) ours after death.

neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Stanteture and title of certifier 44164 -2. HEGAZILMO 30. Name and Address of person who completed cause of death (Item, 23a) (Type, Print)
46 B Thomas Johnson Drive, Frederick MD 21702 A.Z. HEGAZ'

State Registrar

31. Date filed (Month, Day,

Inomas

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32. Registrar's Signature 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Susan С. Koh1 2007 16, /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2√ F Days Hours Min 53 Director 219-76-4874 29, 1953 MD Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Tyres 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 838 N. Eutaw Street 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ed Kohl Mildred 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Kohl Brother 2023 Norhurst Way, North, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Oaklawn Cemetery 1/18/07 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Sam line Eline Funeral Home Reisterstown, MD 21136 23a. Furt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weels /Medical Due to (or as a confequence of): Examiner won Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Syndrame 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) Injury 5 | Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of fleath (Item 23a) (Type, Print) N. Charles St. Bolt. Mb 2120% 6701 31. Date filed (Month, Day, 32. Signature Year) State JAN 2 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edward d lenned 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calumb, A Howard pynty beneral 405/1491 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 180 M 2□ F Yrs. 86 New York Director 524-22-0555 7-25-1920 Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle Item 27 is marked other than "natural", or Items 23a or 28e-1 ebox other traumatic event, it a Medical Examinar must be notified at 1X Yes 2 No Director Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8413 Shears Court U.S.A. 20723 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White 5 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Cotlege (1-4or 5+) Elementary/Secondary (0-12) 4 Printer Washington Post 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Elmer B. Kennedy Julia Buchmeier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Paul Joseph Kennedy - Son 8413 Shears Court, Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
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Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery! 1/22/2007 Silver Spring, Maryland 21. Signature of Fun cal Service Lucinsee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 2078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se 051 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 1 ☐ Yes 2 **(**Vo Be 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X FR/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Intury 5 Pending after death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after c To the Funerel Direc completely filled in by 4 - Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D41320 Jn 15,200 ody 4 Colubia nd 2044 10 person who completed cause of death (Item 23a) (Type, Print) w 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of pers in who completed cause of death (Item 23a) (Type Print)

32. Registrar's Signature

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RUTH LOVISE

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29c. License number

29d. Date signed (Month, Day, Year)

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Balto, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Agim Meka 11:53 P M January 18, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Essex 168 Wiltshire Rd. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 7, 1947 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2 □ F Albania 212 47 1968 60 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examilier must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Essex Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 168 Wiltshire Rd. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder **Appliance** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fetije Spahija Sali Meka ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 168 Wiltshire Rd. Baltimore, Maryland 21221 Erenik Meka (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/20/2007 Oak Lawn Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) ture of Funeral Service Licenses 22. Name and Address of Facility
Bruzdzinski Funeral Home\_P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immidiate Cause (Final **Physician** disease or condition resulting in death) YUNLIEUS. eno(orcinano /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 042910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RM.442 1650 Orleans uliel. 31. Date filed (Month, Day, Registrar's Signature State JAN 22 2007 Registrar

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Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra <u>ance</u> .		1 ☐ Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		0		atory or other mator	. ,	01/2	2/2007	Wald	dorf, N	MD.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 40be 620 A 01 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) <u>Baltimore</u> Rosewood Center Owings Mills
If Under 1 Year | Munder 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1**X**M 2□ F Yrs. 215-74-8380 67 Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ▼Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 USA 1343 W. 41st Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James L. Matheny Opal F. Carder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosewood Lane, Owings Mills, MD 21117 Rosewood Records 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) CF/MR 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

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**Physician** 

/Medical

**Examiner** 

Director

Funeral

Be Completed by

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ital Hygiene. nd other then "natural", or Items 23e or 28e-f show event, it e Madical Examination to positive at

permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Is marked or any injury or other treumatic eve

use as the burialattending physician the After this

P.O. Box 68760

Division of Vital Records,

The law requires that the death certificate be exec Hospitel or Attending Physician: death. 4 hours after death.

Certification: 29a. Certifier Medical 29b. Signature and title of perifier

3 T Suicide

4 - Homicide

Registrar

6 Could not be determined

pman, M.D., F.A.C.P.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

OWINGS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For Stata Registrar		State of I	Marylar		artment <i>rtificate</i>			lental Hy	/giene	/         /	0	268
	Dhusia		1. Decedent's Name (Fire	st, Middle, La	st)						2. Date of De			3. Tii	me of Death
	Physic /Medi		MARY	M. I	MCQUAY						Jan.	16	у <sub>Үөаг</sub> 2007	9:	10 a <sup>M</sup>
	Exami		4a. Fecility Name (If not i	-		er)		4b. City, To	wn, or Lo	cation of Death			. County of Dea		
			Suburban H				·	Beth		Hadas 04 Ha	T		ontgome		
	Funeral Director		5. Social Security Number 231-30-5750		ex □M 2X□F		last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Bi (Month, Di	ay, Year)	C	ountry)	tate or Foreign
			Usuel Residence of Dece	1		81					May 2,	192	5 Nor	th Ca	rolina
	ryland		10a. State 10b.	County		10c. Ci	ty, Town or Lo	ocation						10d. Insi	de City Limits
	e Ma Be-f s	cto	MD Mo	ntgome	ery	S	ilver :	Spring						1	Yes 21 No
	uth with the Marylan 23e or 28e-f show ust be notified at	Director	10e. Street and Number		# ·			10f. Zip C				10g. Cit	izen of What C	ountry?	
	sath v	erai	815 Thayer	Ave.		F (- )	10		0910				USA		
	s after deal,	Funerai	11. Marital Status  1 Never Married	Married	12. Was Decede Armed Force 1 ( Yes 2 (	s?	J.S. 13.	was Deceder If Yes, specify	Cuban, N	nic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whi		in,
036	urs aff	by	3 XWidowed 4 □ [		If Yes, Give Year or Date			1 ☐ Yes 2 ☐	No S	pecify:			Specify: B	lack	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ather than 'natural', or items 23e or 28e-f show and, the Modical Exprinter must be notified at	Completed	15. [ (Specify on	Decedent's Ed	ducation de completed)		16a. Dece	dent's Usual (	Occupation	n ng most of worki	ina	16b. K	ind of Business		
21	within ene. than	햩	Elementary/Secondary		College (1-4c	or 5+)	life.	DO NOT use	retired)	ig most of work	ing .				
2	e filed with Il Hygiene other the vent, the		llth 17. Father's Name (First,	Middle ( act)			Nurse	2	10	Adamba da Nicora	· /=		elf Emp	loyed	
Maryland	ould be filed Mental Hyg Arked othe atic event,	Be	Manuel Kel						-	Mother's Name			Sumame)		
Ξ	nd 2 should be lth and Mental 27 is marked of traumatic eve	2	19a. Informant's Name/P		Type, Print)		19b. Mailir	na Address (5	Street and	Fannie Number or Rura			r Town State	Zin Code)	
	C = N L		Maude Alsto	n/Sist	er		5922	13th Sington	St. N	.W.		o., o.,	· · · · · · · · · · · · · · · · · · ·	_p	
9		9	20a. Method of Disposition			20b. I	Place of Dispo				Date	20c. Lo	cation - City or	Town, Sta	te
Ē	Pages nent of ant: If it		1 ⊠Burial 2 □ Cre 1 □ Donation 5 □			10	enwood			1-24-	-2007	Wash	ington,	D C	
Baltimore.	permit. Pages: Department of H Important: If ite any injury or of		21. Signature of Funeral	Service Licen	1500	00	22	Name and	Address of					Б.О.	
	6 5 5 0 5		111/	01/10	usua	W.		<u> 1217 91</u>	h st	. N.W.	Washir	igtor	1. D.C	2001	1
y 16,2007	cate be executed (cate be executed physician and street burial-transit street burial-transit categories).	cal Examiner	23a. Part. Inter the dis shock, or heart failuimmediate Cause (Final disease or condition resulting in death)  Sequentially list condition from the cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Ire. List only	b. Due to (or a d.	as a consequence	FUOLEN juence of):			EMIA		rrest,		Approx Interva Onset	Infate and Death
anuar groan O. Box 6	the death certify the attending y the attending iched for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregin the past 12 month 1 ☐ Yes 9 ☐ Unknown		23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	ldeath 3□	Ectopic preg				2	23d. Date of del Month	ivery Day	Year
:	The law requires that ate has been signed b	by P	Part II. Other significant			but not res	ulting in the ur	nderlying caus	se given in	Part I.	23e. Did t	obacco u	se contribute to	the cause	of death?
MCQUay Vital Records.	v requir been si should	ted	SZ	PTICE	MIA						10	Yes 2	<b>2</b> 00 3□Pr	obabiy 4	Unknown
Sec	alawa nasb	Completed									24a. Was	osv	24b. Were au	topsy findi	ngs available of cause of
) E		S									perfo 1  Yes	rmed? 2 No	death? 1 ☐ Yes	2□ No	
Z Z	Physician: this certific	Be	25. Was case referred to examiner?		Hospital:					Place of Death		/			
- 6	Phys r this sral di	7:10	1 Yes 2 No 27. Manner of Death	-	28a. Date of In	iury	ER/Outpatien 28b. Time of		Injury at	☐ Nursing Hon	ne 5 🗆 Resid 28d. Describe t			eify)	
≥ no	Attending Phrdeath. sctor: After they the funeral	ation	1 Vatural 5 C	Pending investigation	(Month, E	Jay Year)	Injury	м	Injury at Work?				, , , , , , , , , , , , , , , , , , , ,		
MaYy M、McQuay Division of Vital Records	To the Hospital or Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;		Could not be determined	28e. Place of I building,	njury - At ho etc. (Specif	ome, farm, stre	eet, factory, o	ffice	2	28f. Location (5 City or Tow	Street and vn. State)	d Number or Ru	ral Route I	Number,
3	he Hospi n 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one)	Certifying Phy fedicel Exam	ysician: To the bes iner: On the basis and manner:	of examina	wledge, death tion and/or inv	occurred at t estigation, in	he time, di my opinio	ate and place, a n, death occurre	and due to the e	cause(s) date and	and manner as place, and due	stated. to the cau	se(s)
	To t To t	Σ	29b. Signature and title of						cense nur				signed (Month		
			Miller	- Kus	yomo			0.	2330	8		TAN	VARY	17,2	007
_	P		30. Name and address of Vi CTOR M.	PRIECE	completed cause of $\mathcal{M}.\mathcal{D}$ .	death (Item	1 23a) (Type, F 20 ROC	Print)	se i	DR. #	4100	B	E THES O	A A	10 20877
	Sta Registr		OT. Date med (Mornin, Da)	v. Year)	OZ. Hogis	trar's Signa	ture	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** JANUARY 0125 A M LORRAINE MANNS 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE OF BALTIMURE SINAI HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M XXX 48 Director 01/12/1959 214-84-7072 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at BALTIMORE MD PIKESVILLE 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3928 SQUIRE TUCKS WAY 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give<sup>2</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) STATE EMPLOYEES Elementary/Secondary (0-12) College (1-4or 5+) CREDIT UNION OF MD MANAGEMENT 12TH 2 YRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH MANNS AGNES BROOKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. DONTAY MATTHEWS / SON 3928 SQUIRE TUCKS WY, PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Murial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) ARBUTUS MEM. PK. 1/23/07 BALTIMORE CO, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature Juneral Service Licensee ter the sease, or complications that caused the definition of the sease, or complications that caused the definition of the sease of dying, such as cardiac or respiratory arrest, rhe strailure. List only one cause on each line. 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Interval Between Onset and Death Imme Cause (Final disea or condition resulting in death) **Physician** CORONARY ARTERY 20 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 RENAL FAILURE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLITUS 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

3

SURGEON

32. Registrar's Signature

eter W. Cho

PETER WICHO MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

D41129

2485 WEST BELVEDERE AUGNUE BALTIMORE, MARRYLAND 21215

JANUARY 16, 2007

	_	1 - State Registrar	e or iviaryiari		rtificate of		•	Reg. No.	2007	01270
Physicia /Medica		1. Decedent's Name (First, Middle, Last)  Kimberly D. Pik	e				2. Date of D Month Janua:	Day	Year 2007	3. Time of Death  11:15p M
Examine		4a. Facility Name (If not institution, give street and Carroll Hospice Dove	,		4b. City, Town, o	or Location of Deat		4c. Co	ounty of Death	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖫	7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of B (Month, E Jan 18	ay, Year)	Cou	place (State or Foreign intry)
ne Maryland 8a-f show otifled at	ector	Usual Residence of Decedent  10a. State 10b. County  MD Carroll		y, Town or Lo ersbur	g					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the 23a or 2	a Dir	10e. Street and Number 6603 Marvin Avenue			10f. Zip Code 217	84			n of What Cou SA	intry?
paritimities, interpretable and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	1 Never Married 2 Married 1 Yes	Decedent Ever in U. d Forces? fes $2 + No$ , Give $\Lambda$ or Dates:		1∐ Yes 2∭MNo		Specify Yes or N to Rican, etc.)		. Race - Ameri Black, White, pec <i>ify:</i> Whi	, etc.
within 72 h within 72 h iene. than "natu	Completed	15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12)  Colle	ted) ge (1-4or 5+)	(Give life. L	dent's Usual Occu kind of work done DO NOT use retire 1ry coor	during most of wo	rking	1	of Business/Ini	-
uld be filed Mental Hyg irked other	o Re C	17. Father's Name (First, Middle, Last) Roland C. Singleton				18. Mother's Nai	me <i>(First, Middl</i> ia DuBre		urname)	
and 2 sho and 2 sho salth and 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Gretchen Rankin (frien				and Number or R. d., Woodl				p Code)
Daltillore Dearmit. Pages 1: Department of He Important: If item any injury or oth		20a. Method of Disposition  1 L	ioni State		sition (Name of matory or other pla 1d Cemet	ery 1-27	Date 7-07		tion - City or To ${\sf sville}$ ,	
parit. Departr Importa any inji		21. Signature of Funeral Service Licensee	*	22 P	Name and Address	ess of Facility Hail	ight Fur	neral I	Home &	Chapel
Physician		23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	nat caused the death on each line.	n. Do not ent					764	Approximate Interval Between Onset and Death
	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e to (or as a consequent of to (or as a consequent of to (or as a consequent of to (or as a consequent of to (or as a consequent of the co	uence of):						
the death certific	Physician/Me	in the past 12 months?	, outcome pf pregna ive birth 2 □ Feta regnant at time of d inknown	Ideath 3□	]Ectopic pregnanc ] Other <i>(specify)</i> _	у		230	d. Date of delive	rery Day Year
law requires that as been signed be 2 should be deta	2	Part II. Other significant conditions contributing	to death but not resu	ulting in the ur	nderlying cause gi	ven in Part I.				the cause of death?
The law resate has be page 2 sho	Completed						24a. Wa auto per 1∐ Yes	s an ppsy formed?	death?	opsy findings available ompletion of cause of
ysician: ysician: s certification director, p	10 Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA Oti	26. Place of Dea			Wither (Specie	W Hospice
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		27. Manner of Death  1 Natural 5 Pending investigation	Date of Injury Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?  Yes 2 □ No	28d. Describe			W HOSpice
tal or Atters after de al Directe led in by the	Certification:	4 Homicide determined	lace of injury - At ho uilding, etc. (Specify	v)			City or Te	own, State)		al Route Number,
e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To a Medical Examiner: On the and	o the best of my kno he basis of examina manner stated.	wledge, death tion and/or in	n occurred at the t vestigation, In my	ime, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) ar e, date and pl	nd manner as s ace, and due t	stated. to the cause(s)
To th within Comp	Me	29b. Signature and title of certifier  Very title	ene munif	۱, N	29c. Licens	se number	7		signed (Month,	Day, Year)
10	-	30. Name and address of person who completed	cause of death (Item	23a) (Type,						
Stat		31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture	cus 2					
Registra DHMH 17 Rev 1/200		JAN 2 2 2007	property -	130	2342)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State o	of Marylar		artmen rtificate					giene Reg. No.	0.0	7	012	71
	Physici	an	1. Decedent's Name (First, Middle, I	,							2. Date of De		0.0	Year	3. Time of	
	/Media		Lucille M. Purce								Januar		, 20		8:50	Дм
	Examir	er	4a. Facility Name (If not institution, g						Location of	of Death				of Death		
			Franklin Woods N 5. Social Security Number 6	Sex	TOME  7. Age (In yrs.	last hirthday)	Rose		If Under	24 Hrs.	8 Date of Bir		art1	MOre	place (State o	or Foreign
	Funeral Director		234-03-4205	1 □ M 2/CXF	9		Months	Days	Hours	Min.	8. Date of Bir (Month, Da 08/10/	910		Cour	Virgi	inia
			Usual Residence of Decedent								007.07			,,,,,,	- · · · · · · · · · · · · · · · · · · ·	
	urylan show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							1	IOd. Inside Ci	-
	the Marylar 28a-f show	cto	Maryland Harford	1	Fa.	llston									1 🗌 Yes	<u>₹</u> 7X140
	with th	ă	10e. Street and Number				10f. Zip					10g. Citiz		hat Cour	ntry?	
	eath w	erai	1105 Mill Creek		edent Ever in U	19 12 1	210		ionanio Ori	sin2 /Sn	noëv Voc or No	U.S		Am ori	can Indian.	
	iter d	by Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Fo	prces?	7.3.	f Yes, spec	ify Cuba	n, Mexicar	i, Puerto	ecify Yes or No Rican, etc.)			k, White,		
036	al', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Gi Year or D	ve		1□Yes 2	2⊠ No	Specify:				Specify:	Whi	te	
21215-0036	72 hours after death with the Maryland Instural; or Items 23a or 28a-1 show disal Evant, as must be indiffed at	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	kind of wor	k done o	turina mas	t of work	ina	16b. Kir	d of Bu	siness/In	dustry	
2	ithin han "	npie	Elementary/Secondary (0-12)	College (		life.	DO NOT us	e retired	)		9		_			
12	iled w Hygiei her ti		17. Father's Name (First, Middle, La	ct)		Time	eeper	<u>-</u>	10 Mothe	ela Alama	(First, Middle	Air				
and	d be funtal }	Be c	Earl Hardwick Ma	•							Farnsw		ournanne	<b>3</b> )		
Maryland	2 should be filed within 72 hours after dea and Mantal Hyglene. Is marked other than "natural", or items raumatic avent, it a Madical Examinatin	2	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			I Route Numb		Town. S	State. Zio	Code)	
M	nd 2 salth ar		Edwina Lou Reid		er)						imore,					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any jointy or other traumatic avent, it is Medical Exert act must be indiffied at any eight.		20a. Method of Disposition		20b. I	Place of Dispo cemetery, crer					ate				own, State	
E	Page nent c ant: If ary or		1 ☐ Burial 2 ☒ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe							1/22	/2007	Balt:	imor	e, M	arylar	nd
alti	permit. Departm Imports any inju		21. Signature of Funeral Service Lic	ensee							Funera		_			
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	Physician		23a. art the disease, or co shock, leart failure. List on Immediat. Cause (Final disease or condition		caused the dea each line.					cardiac	r respiratory a	rrest,		1	Approximate Interval Bette Onset and I	waen
	/Medical Examiner		resultin M. death)		(or as a consec		HEROL	laje	=						uay	
	Lxammer	_	Sequentially list conditions,	b. Due to	(or as a consec	mence of.								_		
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate name. Enter I In Jerty ing Cause (Disease or injury	540 10	(0) 43 4 00/1360	quonce ory.										
Ć,	certificate be executed iding physician and ise as the bural-transit	Еха	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):										
8760,	cate be chysicis the bur	dicai		d												
9	ntifica ng ph	Med	IF FEMALE:													-,-
Вох	death certific e attending p ad for use as (	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregnation in the come of pregnation in the come of pregnation and the come of th	al death 3	Ectopic pre					2	3d. Date Mon	of delive		Year
0	0 0	ysic	1 ☐ Yes 2 XNo 9 ☐ Unknown	4∐ Prega 9∐ Unkn	nant at time of o	death 5	Other (spe	ecify)							Juj .	041
٥	g g g		Part II. Other significant conditions	contributing to d	leath but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco us	e contri	bute to th	ne cause of d	leath?
Records,	uires sign	Completed by	Dementia , Breas	t Cancer	:	ŭ	, ,				1 🗆 '	Yes 2X	<b>X</b> No	3 🔲 Prob	ably 4 🗆 L	Jnknown
202	≥ O 3	lete									24a. Was	an	24b. W	ere auto	psy findings	available
Re	0 5 0	omp									autor	osy irmed?	pr de	rior to cor eath?	mpletion of ca	ause of
Vital	iicien: Th certificate rector, pag	a	25. Was case referred to medical	1					26. Place	of Death	1 Yes			Yes	ALA INO	
f V	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 DO	A Othe			ne 5□Resi		Othe	r (Specif)	y)	
n of			27. Manner of Death  1 ☒ Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28	8c. Injury Work	at ?		28d. Describe l	how injury	occurre	d		
sio	Attanding r death. sctor: After by the fune	cati	2 Accident investigat 3 Suicide 6 Could not	ion			М	101	/es 2□	-						
Division	or Attano after death Director: I in by the	Certification:	4 Homicide determine	289. Place	of Injury - At h ing, etc. <i>(Speci</i> i	ome, farm, str fy)	eet, factory	, office		1	28f. Location (3 City or To	Street and wn, State)	Numbe	r or Rura	I Route Num.	ber,
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the		29a, Certifier 1XXCertifying	Physicien: To the	hest of my kar	wiedze dece	occured t	at the tim	e date an	d place	and due to the	Called/al	and man	ner as c	tated	
	e Hos 24 ho e Fun etely	edical		eminer: On the b												)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature 1 d title of certifier	2 .			29c.	. License	number			29d. Date	signed	(Month,	Day, Year)	-
	2		1/pm to	astol			D	4000	8(			Janua	arv	22.	2007	
	1		30. Nam of d address of person wh	o completed caus	se of death (Iter	п 23а) (Туре,	Print)						-	- /		
-	H		Jim Parshall, 91	05 Frank	lin Squ	uare Dr	.,_Ba	ltin	nore,	Md.	21237					
	Sta Registr		31. Date filed (Month, Day, Year)	2007	lagistrar's Signa	ature for	and .	•								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 14, 10:50 January 2007 Esperanza Castro Palting /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 06/22/1910 5. Social Security NumbelUnk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 👿 F Director 96 Philippines Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Mudicul Examiner must be notified at Director 1X Yes 2 No Philippines N/A Sampaloc/ Manila 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "--- any injury or other traumette." with or Items 23a 707 M. Earnshaw Street N/A Philippines Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pharmacist Pharmaceutical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Engracia Ruiz Santos Castro 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberto Lagdameo/ Son-in-Law 16308 Bawtry Court Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/21/2007 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to forms a consec Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Lan that initiated events resulting in death) Last iding physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ► No 9 Unknown 9 Unknown signed by Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 3 Probably 4 | Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an this certificate 2[ 1 Yes : After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 1 chartient 28a. Date of Injury (Month, Day Year) 27. Manner of Deal 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No filled in by the Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (T asr (cl 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

			1 - For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artment of l rtificate of	Health a	and Ment		iene () (	7	01273
	Dhyois		1. Decedent's Name (First, Middle	e, Last)					2. Da	ate of Deatl	1		3. Time of Death
	Physic /Medi		ETHEL ELLE	N PORTER					Ja	<sub>onth</sub> Inuary	<sup>Day</sup> 16, 20	907 007	7:05 a M
1	Exami	ier	4a. Facility Name (If not institution		,		4b. City, Town,	or Location of	of Death		4c. County	of Death	
			Prince Geo					verly			Pri	ice (	George's
	<ul><li>Funeral</li><li>Director</li></ul>		5. Social Security Number 577-32-7894	6. Sex 1 ☐ M 2 🖾 F	7. Age (In	yrs. last birthday, 6 Yrs.	Months Days		Min. Be	te of Birth fonth, Day, 2 • 30	Year) 1920	Cour	place (State or Foreign htry) yland
	land		Usual Residence of Decedent  10a. State 10b. County		10c	. City, Town or L	ocation					1	Od. Inside City Limits
	Mary -18h	tor	Maryland Prin	ce George		Bowie						1	1⊠Yes 2⊡No
	r 28a	irec	10e. Street and Number	ce deorge	3 1	DOMTE	10f. Zip Code			10	g. Citizen of W	hat Coun	ntry?
	th wit	Funeral Director	8800 Maple Av	enue			20720	)			U.S.A.		,.
	- dea	ner	11. Marital Status	12. Was Dec		n U.S. 13.	Was Decedent of I	lispanic Orig	gin? (Specify Y	es or No-	14. Race	- Americ	an Indian,
36	or It	y Fu	1 Never Married 2 Marr	ed 1 ☐ Yes If Yes, Gi	2 🖾 No		1 ☐ Yes 2 ☒ No		i, Pueπo Rican,	etc.)		, White,	atc.
Ö	ural'	d by	3 ₩ Widowed 4 Divorced	Year or D	ates:						Specify:	Whi	.te
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פַ	Hyg othe	Be C	17. Father's Name (First, Middle,	Last)			Deore De		y r's Name (First,	Middle, M		_	Lociltop
Maryland	Vid be Venta rked tic ev	To B	Wade H. Colso	n				н	attie V	ermil	lion	,	
al	and the ma	i	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (Street	and Numbe	r or Rural Rout	e Number,	City or Town, S	itate, Zip	Code)
≥ .	and ealth n 27 ner tr		Joseph H. Ower	ıs - Neph	ew	192	9 Westche	ster.	Avenue,	Cato	nsville	, MD	21228
ore	ges 1 of H if itan	1	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from	State 20	<ul> <li>b. Place of Dispo cemetery, crei</li> </ul>	sition (Name of matory or other pla	ce)	Date	2	Oc. Location - C	ity or To	wn, State
Ē	tant:	10	4 □ Donation 5 □ Other (Sp			Metropoli	tan Cremato	ry (	01/19/20	007	Alexand	ria,	Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental thygiene. Important: if item 27 is marked other than "natural", or Iteme 23s or 28s-f show any figury or other treumatic event, the Macical Examinat must be notified at once.		21. Signature of Funeral Service I	icensee	L	m/A	2. Name and Addre						imore Ave.
Y.,	40240		A Const	enel	Da	seh	Gasch's F	unera.	1 Home,	P.A.	, Hyatt	svi1	1e, MD 2078
8			23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on e	acri ine.					ratory arres	it,	Ì	Approximate Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a. KIGHT			- HEMAT	OMA					Chisel and Death
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Rox	death certi	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live b	irth 2 ☐ F ant at time o	etal death 3	Ectopic pregnancy Other (specify)				23d. Date Month		y Day Year
o	by the de	Physician/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□ Unkno		,, 304.11	Other (specify)						
ώ.	requires that the	by P	Part II. Other significant condition	s contributing to de	eath but not i	resulting in the ur	iderlying cause giv	en in Part I.	23	e. Did toba	cco use contrib	ute to the	cause of death?
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VItal	E 15 0	Be	25. Was case referred to medical examiner?					26. Place	of Death Check		2110		
-	Q 12	2	1 Yes 2 No 27. Manner of Death			ER/Outpatient		- I I I I I I I I I I I I I I I I I I I	sing Home 5	Residenc	e 6 □Other	(Specify)	
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	ne Hi in 24 he Fi pletel	edical	one)	xaminer: On the ba and mann	isis of exami	nation and/or inv	estigation, in my of	oinion, death	occurred at the	time, date	and place, and	due to t	he cause(s)
	tive Com	Σ	29b. Signature and title of certifical	selv 13	Jan J	20	29c. License	number		29d.	. Date signed (/		
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	10		30. Name and address of person w		of death (It	em 23a) (Type, F	Print)	_	1	2.12	/>	_	
343	Stat		DK BRAJENDRA M 31. Date filed (Month, Day, Year)	115RA 32-RE	200 egistrar's Sig	nature	KL DRIV	ヒ	CHEVER	LY, L	10 20	785	
	Registra	_	INN 9 0 2		a. am	H. Ace	de la						Ì

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23aPtII per dr Certificate of Death

Reg. No. Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 06:55AM January 13, Phe1ps 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4 Patapsco Road Linthicum Anne Arundel 6. Sex 1X M 2□ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 219-22-6162 78 Aug. 21,1928 MD Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene. and them 27 ie marked other then "naturel", or Iteme 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits rithen "naturel", or iteme 23a or 28a-f show the Mindical Examinar must be notified at 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director Anne Arundel MD Linthicum 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4 Patapsco Road 21090 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Phelps Clara Quandt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cortant: If item 27 is injury or other trau Mrs. Anna Phelps /Wife 4 Patapsco Road Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 17, 20c. Location - City or Town, State 20a. Method of Disposition Donation 5 ☐ Other (Specify) permit. Pege Department of Important: If eny injury or once. Glen Haven Mem. Park 2007 Glen Burnie, MD 21. Signature of Puneral Service Lips 22. Name and Address of Facility Singleton Funeral Home, P.A. 01364 1 Second Avenue SW Glen Burnie, MD 21061 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementa Advanced **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ettending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 1 ☐ Yes 2 ☐ No 9 Hinknown 9 Unknown should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Aspiration Pneumonia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 autopsy 1 ☐ Yes 2 ☐ No 2. No Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28c, Injury at Work? 28d. Describe how injury occurred 28b. Time of 1. Natural 5 Pending i efter death.

i Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide nt bellif 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 D 50 470 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), SRIDHAR, ATLUAL, 8109 RICHIE asadena MD 21122 High way 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2007 Registrar

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		For	State of Ma	aryland				lealth and Mo	ental Hy	giene	9		O 1 O mg pm
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Funeral	2.5	Holy Cross Hospi  5. Social Security Number 6. S		e (In yrs. las	st birthday)	If Under 1 Y	/ear	Spring If Under 24 Hrs.	8. Date of Bir (Month, Da	rth _	_	). Birthplace	e (State or Foreign
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alth a		Manavata Vaidya/	sister		10004	Gree1	2 <b>y</b>	Avenue Si	lver S	prin	g, Ma	rylan	d 20902
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show yinjury or other traumatic event, the Medical Examiner must be notified at anone.		21. Signature of Funeral Service Lice	nsee		De 22	2. Name and A onalds	Addres	ss of Facility Funeral H	ome &	Crem	atory	, P.A	١.
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ath c	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal de	eath 3	Ectopic pregr					23d. Date of Month	-	y Year
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w requires been six should be	lete								24a. Was		24b. We	ere autopsy	findings available
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nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🔀 Inpatie	nt 2 EF	R/Outpatien	it 3□ DOA	Othe	er: 4 Nursing Hom	ne 5□Res	idence	6 □Other	(Specify)	
ine ite		27. Manner of Death  11 Natural 5 Pending	28a. Date of Inju (Month, Day	ry 28 Year)	8b. Time of Injury		Injury Work		8d. Describe	how inju	iry occurred		
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or At or At fiter d Direct in by	i.E	4 Homicide determined		. (Specify)	e, tarm, str	eet, factory, of	пісе	2	8f. Location ( City or To			or Hurai Ho	oute Number,
pital ours a leral filled		29a. Certifier A XX Certifying	nysician: To the best	of my knowle	edge, death	n occurred at t	the tin	ne, date and place, a	and due to the	cause(s	s) and manr	er as state	ed.
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	(Check only one) 2 Medical Exa	miner: On the basis of	examination	n and/or in	vestigation, in	my o	pinion, death occurre	ed at the time	, date ar	nd place, an	d due to the	e cause(s)
To the vithin To the comp	Me	29b. Signature and title of certifier	1			29c. Li	icense	e number		29d. Da	ate signed (	Month, Day	y, Year)
1		<b>)</b> (()) <b>%</b> ()	W/			D6:	288	35		11	18/07		
10		30. Name and address of person who	completed cause of d							1			
1		Od Date Stat (Marth St. V.	) 0. MAN	-		orest (	G1e	en Road Si	lver S	prin	ig, Ma	ry1an	nd 20910
St Regis	tate	31. Date filed (Month, Day, Year)	32. Backtra	ar's Signatur	re	conti s							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Welling Month Rache1 Ruff 2007 7:00p January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6575 MacBeth Way Eldersburg Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2√☐ F 217-28-6592 Director Oct 17 1929 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Exa<u>miner must be notified at</u> Carrol1 MD Eldersburg Director 1 ∐ Yes 2**火**□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6575 MacBeth Way 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 Widowed 4 Divorced er than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other thar other traumatic event, the M public relations coordinator health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Brayshaw Welling Hannah Sykes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia R. Smith (daughter) 4935 Ijamsville Rd., Ijamsville, MD 21754 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation 1–23–07 20a. Method of Disposition 20c. Location - City or Town, State of Department of Important: If it any injury or conce. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses ▶ Paigerfaight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) ballation **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a compequence of) Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only offe, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2<mark>⊡</mark> No Certification: To 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: filled in by within 2.

To the

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 950240

State Registrar

Medical

and address of person who completed cause of death (Item 23a) (Type, Print)

ed 5 Horach Mn 447. East Main 6+ Westween ten Mn 31. Date filed (Month, Day, Year)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 $\overset{\mathsf{Day}}{1}4$ **Physician** 2007 11:00aM В. Russell Delores /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 3400 Brompton Ct. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) 11 06 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) 1 □ M 2 🖔 F 74 Yrs MD **Director** 215-28-3999 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 XYes 2 No Baltimore Director NA MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ural", or items 23a or Examiner must be i 21207 U.S.A. death v Funeral 3400 Brompton 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: þ Widowed 4 □ Divorced Black Completed th and Mental Hygiene. 7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Social Security Adm Analyst <u>12th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Strong Columbus Hill ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If Item 27 Is any injury or other trauonce. Bryan Russell-Son 7775 Beadfild Ct., Manass, VA 20112 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park 1/20/07 Baltimore, Md 4 Donation 5 Dother (Specify) <sup>22. Name and Address of Facility</sup> March F/H West 4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licen-21215 23a. Part 1. Enter the disease, or conglications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) divascular Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a co sequence of) Examine Due to (or as a consequence of): attending physician a for use as the burial-Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should certificate has birector, page 2 s Certification: To Be

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, heral Director: A filled in by the fu

Baltimore, Maryland 21215-0036

				24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□ DOA	Other: 4 Nursing H	ome 5 Residence 6	Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, of	fice	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	nysician: To the best of my knowledge, death on the basis of examination and/or inversed and manner stated.				
29b. Signature and title of certifier	_	29c. Li	cense number	29d. Date	e signed (Month, Day, Year)
> Ofperling	la	D	28987	1/1	17/07
30. Name and address of person who	completed cause of death (Item 23a) (Type, Pr	rint)			
CARL SPERHNGY!	U.D. SEOI LOCH RAVE	NBL	UD BAL	10. MD 212	39

State Registrar

Medical

31. Date filed (Month, Day, Year)

JAN 2 2 2007

To the Hospital of within 24 hours af To the Funeral E

32. Registrar's Signature

			1 - For State Registrer	State o	of Marylar	-	artmen rtificat			and M		gienę. Reg. Nd:	7	7	012	78
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	/Medic Examin		4a. Facility Name (If not institution, g  JOHNS HOPKI						Location o	f Death	MD		County of D			
	Funeral Director		246-52-0380	Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 67	/ast birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir Month, Da	th y Year)	39	Birthplac Country	(State or Fo	oreign
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with the	n or 28a	Direc	10e. Street and Number				10f. Zip		216			_	zen of What		n	
rs after death	if health and Mental hygiene. Item 27 ie marked other iten "naturel", or iteme 23a or 28a-f ehow other treumatic event, the Medical Exeminer roughe incillied at	by Funeral Director	2915 North Lo  11. Marital Status  1 Never Married 2 Married  30 Widowed 4 Divorced	12. Was Dec	edent Ever in U orces? 2 XNo		Was Deced If Yes, spec	dent of His		gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	-   1	14. Race - A Black, W	merican hite, etc	÷.	
vithin 72 hou	ne. hen "nature e Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education		life.	kind of wo DO NOT us	rk done d	uring most	t of workin	ng	N	nd of Busine S. Pu	bli	.ć	
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should	nd Men marke imatic	Ţ	John D. Harre 19a. Informant's Name/Relationship			19b. Mailir	ng Address				Slauc			a. Zip C	ode)	
and 2	ealth ar n 27 io ser treu		Lemuel Rouson	-Son		3706	Wint	erb		Roa	ad, Ba					216
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To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon								ed (Month,	Dey, Year)	
F > F 0		30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)  YAZININ MOYGIES 4940 EASTERN ANSWER BALTION										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 06 MAE TEWAR anuary 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hair altimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2□ F Days 217-54-1467 Usual Residence of Decedent **Director** MAR 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director 10g Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12+HGRADE PROCESSING SPECIALIST , 17. Father's Name (*First, Middle, Last*) 18. Mother's Name (First, Middle, Maiden Surname) Be -DWARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. TIHORE, Mb. 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State BUTUS CEMETERY 01-Donation 5 ☐ Other (Specify) 23-01 22. Name and Address of Facility 2140 North Fulton Avenue Mb 2/3/ of Funeral Service Licens Signatur Home Baltimore nt1. Ente the disease, or complications that part failure. List only one cause on or complications that car sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, I prediate Ca se (Final lease or condition sulting in death) CARCINOMO **Physician** STATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day 5 ☐ Other (specify) signed by the a P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1+05/°CL 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death. 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 W. Belvedere AJR, Baltimae MI) 21210 10 Step hon

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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician**  $1^{D_4^{D_4^{y}}}$ 2007 Streater 7:30a. M Eva Annie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Future Care Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 I Month, Day, Year) 20 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🖾 F VA Director 218-05-7724 87 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Show X☐Yes 2☐No notified Director Baltimore NA MD 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21215 U.S.A. 3815 Dolfield Ave death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Black þ 3 ☐ Widowed 4 € Divorced 'natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Seamstress Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Reid Edgar Jones ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n Brother-In-Law 3815 Dolfield Ave, Baltimore, Md 21215 Ernest R. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ## Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or King Memorial Park 1/22/07 Randallstown, 21. Signature of Funeral Service Licens 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, any 21215 23a. Part1. Err er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C v se (Final disease or c dition Physician congestive heen disease or c indition resulting in death) /Medical Due to (or a a conse uence of): Examiner thorosclore if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached the 9□Unknown 9 ☐ Unknown as been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has The page performe 2 ☑ No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannut of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Watural 5 ☐ Pending To the Hospital or Attendil within 24 hours after death.

To the Funeral Director; A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Craftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1-17-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32, Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OI 1<sup>Day</sup> **Physician** 2007 Smith 1:45a.M Gertrude Romana /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Future Care Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01 (Month Day, 29) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 74 MD Director 215-30-0670 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified et 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Baltimore NA MD 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 7 is marked other than "naturai", or items 23a or traumatic event, the Medical Examiner must be re 21244 U.S.A. 3409 JoAnn Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify Specify: þ 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm Claims Adjuster 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event Be Rachel Sewell James E. Sampson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Geraldine Bowman-Sister</u> 3409 JoAnn Drive, Baltimore, Md 21244 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X□ Burial 2 □Cremation 3 □Removal from State King Memorial Park 1/20/07 Randallstown, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Ma Pathand Address of Egitt 21215 4300 Wabash Ave, Baltimore, 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse (Final disease or condition resulting in death) CEREBRO VASCULAR **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician end for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.O. 1 5 Other (specify) ate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes → No autopsy performed? Yes 2 2 No Yes i or Attending Physician: after death. funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 **X**ONo 1 Inpatient 2 ER/Outpatient 3 DOA ို 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident To the Hospita ... within 24 hours after death.

To the Funeral Director: Aftractive in the funeral of the fune 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year) JAN 2 2 200

29b. Signature and title of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVI

OLD COUNT Nd, MO 21133 5400 age!

29c. License number 0 3 7 3 3

29d. Date signed (Month, Day, Year)

17,2007

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs

BALTI MONE

4:28 PM

9. Birthplace (State or Foreign

4c. County of Death

Examiner **Funeral** ns 23a or 28a-f show must be notifled at ural", or items 2 Examiner mus "natural", other than "natu is marked Health a

Physician

/Medical

4a. Facility Name (If not institution, give street and number)

Social Security Number

HUSPIMA

CENTER

Age (In yrs. last birthday)

8. Date of Birth (Month, Day, Months Davs Hours 1 □ M 2 ■ Director 216-48-9886 ΟÌ 58 22 NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 U.S.A. 3047 Seamon Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Post Office Office Clerk 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Sturdivant Richard L. Dean 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1017 Taylor St, Wingate, NC 28174 Carolyn Collins-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. Burial, 2 Cremation 3 Removal from State King Memorial Park 1/20/07 Randallstown, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility t March F/H West 4300 Wabash Ave, 21. Signature of Funeral Service License 21215 Baltimore, Md 23a. Part1. En er the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HYPEKKALEMIA **Physician** 5 MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 YEARS REMAL DISEASE STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed 4164 10 YEARS BL000 resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has 92s autopsy performed? res 2 No page certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 PER/Outpatient 3□ DOA 2 27. Manyer of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D29296 JAMARY severe mo 2007 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 116 GEN BUNNE MC 808 LANDMANK DRIVE (reMAN) LOWDER

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Registrar

31. Date filed (Month, Day,

Year!

2007

32. Registrar's Signature

death with the Maryland Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nn: If item 27 is marked other than "natural", or iten yr or other traumatic event, the Medical Examiner rry or other traumatic event, the Medical Examiner.

3altimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed burial-tran physician the as attending p for use as ģ signed t certificate has this

Division or Vital Records, P.O. Box 68760,

**Physician** Year 03:18 AM JosePH 2007 TANUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKIN'S BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) July 10,1918 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1X M 2 □ F 88 214 01 0981 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Baltimore Middle River 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Dogwood Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give WW II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 21X No 2 Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Draftsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Joseph Svec Sr. Josephine Moravec မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J. Svec (Son) 2957 Sunderland Ct. Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 1/23/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA one week Due to (or as a consequence of): PROSTATE LANGER Sequentia ly list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2/2/No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Z Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury hours after death. uneral Director: Af ely filled in by the fur 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAND 4940 EASTERN AVENUE BATIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

			For State Registrar	State o	f Marylai		artment of H			- Simon	007	01285		
	Decedent's Name (First, Middle, Last)					2. Date of			Reg. No.  Death 3. Time of Death					
	Physici		Barbara Lee Swa			Month January	16,	2007	11:40 M					
	/Medic Examin		4a. Facility Name (If not institution,		nber)		4b. City, Town, or	Location of Deat		T	County of Death	11.40		
	- Admin		1789 Shaftsbury	Crofton			Anne Arundel							
	Funeral			6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year	If Under 24 Hrs		1	9. Birthr	place (State or Foreign		
	Director		578-44-2911	1 □ M 2 <b>X</b> □ F	72	Yrs.	Months Days	Hours Min.	01/12/1	935	Wash:	ington, DC		
	D		Usual Residence of Decedent  10a, State 10b, County		10-0			-						
	anyla shov	5	Total Inside Only Entire											
	Ne M	Director	Maryland Anne A	rundel	Cro	fton						21		
	with	ក់					10f. Zip Code				en of What Cou	ntry?		
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9	d within 72 hours after death with the Maryland jene. r then "netural", or iteme 23a or 28e-f show ttie Madical Examiliar must be notified at	Funerai	1 ☐ Never Married 2 ☐ Marri	Armed Fo ed 1 ☐ Yes	Forces?		f Yes, specify Cuba 1 ☐ Yes 2 [X] No	to Rican, etc.)		Black, White, etc.				
21215-0036	ural',	d by	3 Widowed 4 Divorced		If Yes, Give Year or Dates:			Specify:		Specify: White				
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121	within ene.		Elementary/Secondary (0-12) College (1-4or 5+)  2 Crofton Town Manager						Local Government					
22	e filed wall Hygier other the		17. Father's Name (First, Middle, L	2		Crorto	on lown Ma		me (First, Middle,			ment		
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ē,	- T - 5		20a. Method of Disposition	5011	20b.	Place of Dispo	sition (Name of		Date		ation - City or To	own, State		
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Baltimore,	permit. Pages Department of It important: If ite eny injury or of		21. Signature of Funeral Service L				. Name and Addres					al Home		
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Approximate Interval Between Onset and Death											
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	/Medical Examiner	dicai Examiner	resulting in death)  Due to (or as a consequence of):									3		
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Вох	death certiff e attending id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out				23	23d. Date of delivery					
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Ö	rs after al Dire ed in by	Certification:	4 1 Tionnicide	Buildir	ng, etc. (Specia	ry)			City or Town	i, State)				
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	To the to within 2. To the to complete	Med		and mann	er stated.									
,	5. <u>₹</u> 5.g		29b. Signature and title of celtifier	(7)	MAN		29c License	number /	2	od. Date	signed (Month, i	Day, Year)		
	1	4	July 100	NUCK	WU	)	ne	130-4		1au	16	W T		
l	U		Name and address of person w	no completed cause	e of death (	12 1	A.C.D.	JE DA 3	200 An	MM	DAK :	11121401		
	Sta	te	31. Date filed (Month, Day, Year)	32	gistrar's Signa	ature	100/04	1010	111,000	1013	10012	MUDI 101		
	Registr	ar	IAN 9 9	2007	A	to figure	or Gard							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician SAUERS** MARGARET ROSEN 1808 PM January 17,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ho spital 0+ Baltimore N/A 13 a Sinai HMOVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 10/24/1921 1 □ M 2 🔽 F Months Days Hours ຶ່SCOTLAND 186-18-6521 85 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 👿 No BALTIMORE Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 POMONA DRIVE EAST #303 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No WHITE Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JOSEPH** HANNA ELIZABETH LITTLE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 2 POMONA DRIVE EAST #303 GEORGE F. SAUERS / HUSBAND BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 01/19/2007 4 ☐ Donation 5 ☐ Other (Specify) TOWSON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Ent. / the disease of of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Discuss or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and physician are the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kes piratore Failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown ESRD 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

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of person who completed cause of death (Item 23a) (Type, Print)

Registrar Signature

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31. Date filed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year) JAN 2 2 2007

29b. Signature and tibe of certifi

(Check only



cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

D29373

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TRAN **Physician** January Month Day 05:30 AM DAM 2001 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Johns Hospita Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 □ F 66 Director 213-23-4468 Jan. 12,1941 Vietnam Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits If than "natural", or items 23a or 28a-f show the Medicul Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Norwich Court Vietnam 21117 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurant Worker <u>Restaurant</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ent of Health and Mental Hit: If Item 27 is marked oth y or other traumatic eventy Be ၉ Unknown Tran T. Diet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chau Nguyen 7 Norwich Court, Owings Mills, MD 21117 Son in law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 1/21/07 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed burial-tren and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 X Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No certificate has page 2 autopsy perform 1∐ Yes 2 No After this certifications funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural (Month, Day Year) 124 hours efter death.

16 Funeral Director: A pletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mari 2007

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Johns Hopkins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mispital

600 M.W. H. St. Balliner MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMIOND ITEM#10a, 10b, perFH, C863, 1/20/07, WS

Amend #18&19a Per Ind C864 Perfyrent of Pleath

Continued to the Perf Index C864 Perfyrence of Pleath Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** LUCILLE TAYLOR 2007 4:20A JAN. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE CITY N/A FUTURECARE HOMEWOOD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/27/1902 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 💢 F Yrs. Director 104 MARYLAND 217-40-0128 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Examiner must be notified at 1 Yes 2 □ No EUTAW BALTIMORE CITY Director <del>1701</del> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 1701 EUTAW PL, APT. 21217 Funeral 417 usa permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23s any Injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE FAMILIES 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS DORSEY DORA Jenkins Jenkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN TRAVERS Trivers/neice 9285 SOARING HILL RD, COLUMBIA, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State STEVENSON AME 01/22/07 SPARKS, MD 4 Donation 5 Dother (Specify) CEMETERY 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Juneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Part Enter the disease, or complications that cause shook, or heart failure. List only one cause on each that caused the deam. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) **Physician** e 0920 /Medical due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → 100 performe Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: AL No မ 1 ☐ Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. an of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2∏No s after death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral C Prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAQAT ALI \$21 N Eyter ELTEW 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 19, 2007 9:00 amM January Walker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Cromwell Nursing Home Parkville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🗙 F 7/19/1940 Maryland Director 216-36-3124 66 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 10 Cloverwood Court Unit 104 U. S. A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Tes Geo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify ρ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 9 Grocery Store Cashier permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth eny linjury or other treumatic event, sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hall Schlatzer Joseph Dorothea Henry Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Walker (Daughter) 127 Riverthorn Road Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State /20 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Bayview Crematory Baltimore, Maryland 21. Signature of Ffuneral Service Licenses 22. Name and Address of Facility Fruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 onn 23a. First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) ementia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learned to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) by the a 9 Unknown cete has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatly? ۵ 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? (es 20 No 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 1 ☐ Yes 2 X No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending death. М 1 TYes 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeref 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

DEAL.

		•	For State Registrar	State of M	Maryland		artment rtificate			nd Me		giene Reg. No		17	0129	
	q		1. Decedent's Name (First, Middle, La	ist)							2. Date of De Month			Year	3. Time of Dea	th
	Physici /Medio		Lillian		Wils	son					Januar		, 20	07	8:40 A	М
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			Hill Haven Nurs: 5. Social Security Number 6.		// t-	and the first state of	Hya If Under	ttsv	LILE If Under 2	IA Uro					orges	
	Funeral Director			1 M 2 TF	Age (In yrs. Ia 83	Yrs.	Months		Hours	Min.	8. Date of Bir <i>(Month, D</i> a April	у, Year) 21 <b>,</b> 1	923		nce (State or For etry) nce Geor	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	ncation							1	0d. Inside City Lir	mite
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	3e or	Funeral Director	3210 Powdermill	Road				0783				_	SA		, .	
	death	ner	11. Marital Status	12. Was Decede		3. 13.	Was Deced	ent of Hisp	panic Orig	in? (Spec	ify Yes or No lican, etc.)	-			an Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be nutified at Once.		1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Force  1  Yes 2 If Yes, Give Year or Date:	X) No		1 Yes, spec 1 □ Yes 2		Mexican, Specify:	Puerto H	ican, etc.)		Black, Specify:	, White, Bla		
Ŏ	72 ho	Completed by	15. Decedent's 8 (Specify only highest gi			16a. Dece	dent's Usua	Occupati	on	of workin		16b. K	ind of Bus	iness/Inc	dustry	
2	ithin ithin	npie	Elementary/Secondary (0-12)	College (1-4c	or 5+)		kind of wor DO NOT us	e retired)	ing most	or working	9					
	lygier her th		12			C1	erk				-				ernment	
Maryland	tbe findal Hedot	Be	17. Father's Name (First, Middle, Las Unknown	()				1		s Name Inkno	(First, Middle,	Maiden	Sumame	)		
Ë	hould de Me mark mark	은	19a. Informant's Name/Relationship	(Type Print)		19h Mailir	na Address	(Street an			Route Numbe	er City o	r Tours	tate Zin	Code	
Ma	nd 2 s lth an 27 ls	1	Rosemary Mason/				Alle				amp Sp	-			0748	
ē,	s 1 ar Hea Item		20a. Method of Disposition	odd L d Lair	20b. Pla	ace of Dispo	sition (Nam	ne of		Da	-		ocation - C			
E O	Pages ent of nt: If i		1 ☐ Burial 2 X Cremation 3 ( 1 ☐ Donation 5 ☐ Other (Spec		.te	<i>metery, crei</i> ntt Cr	-		1	/20/	2007	Wa1	dorf	, MD		
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Lice				2. Name and			KOD					al Home	
			23a. Part 1. Enter the disease, or cor	nplications that caus	sed the death						d Bow		MD .	2071	5 Approximate	
	Discolution.		shock, or heart failure. List only Immediate Cause (Final	one cause on each	n line.			o o, o,g,	00011 00 0		Toophatory a	1001,		,	Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	- u	as a consequ									- (	INE DAY	
	Examiner				as a consequ	erice or).										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	ence of):								-		
	cuted nd ransit	Examiner	that initiated events	C												
Ö,	licate be executed physician and s the burial-transit	Ä	resulting in death) Last	Due to (or	as a consequ	ence of):										
8760,	ate b	dicai		d					_					-		
9	entitic ding p	/Mec	IF FEMALE:	Ole If you system										11.0		
Вох	death certiti e attending p id tor use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3□	Ectopic pre						23d. Date Mont		Day Year	
o.	at the de by the a	ysic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	9 Unknown		alli J	J Officer (Spe	-cuy)								
Δ.	that hed by deta	by Ph	Part II. Other significant conditions	contributing to death	n but not resu	lting in the u	nderlying ca	use given	in Part I.		23e. Did t	obacco u	ise contrib	oute to th	ne cause of death	?
rds	requires that een signed b hould be deta		DEMENTIA								10	/es 2,	⊠No 3	Prob	abiy 4 ∐Unkno	วพก
00	> 0 0	ompieted	DIABETES	MELLIT	US						24a. Was		24b. W	ere auto	psy findings avail	able
æ	0 5 6	E			-							sy med? 2.⊠No	de	ath?	npletion of cause 2₩ No	of
Vital Records,		Be C	25. Was case referred to medical					2	26. Place	of Death	(Check only o				2,40	
of V	S :=	70 E	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpa	atient 2 🗆 E	R/Outpatier	nt 3 🗆 DO.	A Other:	4⊠ Nur	sing Hom	e 5 🗆 Resid	dence	6 Other	(Specify	()	
			27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of li (Month, I	njury Day Yea <i>r)</i>	28b. Time of Injury	1 28	3c. Injury a Work?	it	28	Bd. Describe I	now injur	y occurred	d		
sio	Attending r death. sctor: Atterby the tune	catl	2 Accident investigate 3 Suicide 6 Could not	30			M		s 2□N							
Division		ertification;	4 Homicide determined	28e. Place of	Injury - At hor etc. (Specify)	ne, farm, str	eet, factory,	, office		28	Bf. Location (S City or Tox			or Rura	l Route Number,	
	Hospital 4 hours a Funeral t tely tilled	O	29a. Certifier 1 ✓ Certifying P	hysician: To the be	est of my know	dodgo dost	h conversed o	at the time	data and	l minen e	and reference to the control of the					
	e Hospital 24 hours a e Funeral I	edical	(Check only 2 Medical Exa	miner: On the basis	s of examinati	on and/or in	vestigation,	in my opir	ion, death	h occurre	d at the time,	date and	and mani place, an	ner as si nd due to	ated. the cause(s)	
	To the Hospital or within 24 hours after To the Funeral Discompletely tilled in	Me	29b. Signature and little of certifier	( P			29c.	License r	number			29d. Da	te signed	(Month,	Day, Year)	
	. 4.		> (/llwi	u Bru			10	003	156	3	-	IAN	بدج میں	18	<000>	
	) 1	1	30. Name and address of person who			23a) (Type,		JU )	0					, 3		-
_	2		CHARLES M. BE	NNER OU	D 10	801 L	OCKN	2000	DR 1	# 205	SIL	JERS	SPRIN	45 1	MP 2091	01
•	Sta		31. Date filed (Month, Day, Year)	- T	strar's Signat	ure L.	£ 20	0								
	Regist	ar	IAN 2 2	2007	18 1.162 J 2	J. 14	Market .	40								

			1 - For State Registrar	. 10400	State o	f Marylan	d / Depa		t of H	ealth a	and M	-		71111	0	1292
			1. Decedent's Name	(First, Middle, Las	it)			-				2. Date of De Month	eath Da	V		ne of Death
	Physici /Medi Examir	cal	Gloria 4a. Facility Name (#	Char		Wong		4b. City,	Town, or	Location of	of Death	Janua	ry 1	9 2007 c. County of Dea	9:	12 A <sup>M</sup>
1			Carroll Ho	ospice 2	292 Stor	ner Ave		West	mins	ter,	MD	21157		Carroll		
	Funeral		5. Social Security Nu			7. Age (In yrs.			1 Year	If Under		8. Date of Bi (Month, D			rthplece (St	ate or Foreign
	Director		559-32-516	50	□M 21xF	76	Yrs.					May 27			Liforn	
	land		Usual Residence of t	10b. County		10c. Cit	y, Town or Lo	ocation							10d. Insid	de City Limits
	the Marylar 28a-f show notified at	o	MD	Carrol			Mt. Ai:	W1.7							1 🗆	Yes 2⊠ No
	72 hours after death with the Maryland natural', or iteme 23a or 28e-f show disal Exeminer must be notified at	Funeral Director	10e. Street and Num			L	ML. AI.	10f. Zip	Code				10g. C	itizen of What C	ountry?	
	3a o	O	2948 Lone	esome Doz	nsog er			21	771				US			
	ms 2	Jera	11. Marital Status	SOME DO	12. Was Dece	edent Ever in U	.S. 13.			spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Am		n,
9	or ite	Fü	1 Never Marrie	d 2 Married	Armed Fo	2 ( No					i, Puerto	Rican, etc.)		Black, Wh		
93	ours Feb.	d by	3 Widowed 4	Divorced	If Yes, Giv Year or D	ates:		1 🗆 Yes	2 <b>X</b> NO	Specify:				Specify: Ch	inese	
215-0036	72 h	Completed	(Specit	15. Decedent's Ed y only highest gra	lucation de completed)		(Give	dent's Usua kind of wo	rk done o	lurina mosi	t of work	ing	16b.	Kind of Busines	s/Industry	
12	within ene. then "	шb	Elementary/Secon	dary (0-12)	College (1	I-4or 5+)		DO NOT us	se retired,	)						
121	lied v lygie ther t		12 17. Father's Name (F	First Middle Last			Bookk	eeper		19 Mothe	r'a Name	e (First, Middle		Chang	Compai	<u>ıy</u>
and	ntail h	Be										FIFSI, MIDDIE	s, MaiOe	n Sumame)		
Ž	2 should be filed within and Mental Hygiene. Is marked other then raumailc event, the Me	2	Frank 19a. Informant's Nar	Chan	Tuna Print)		10h Maili	na Addross	/Stroot a		da _	Quan	nor City	or Town, State,	Zin Cadal	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Heelth and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23a or 28a-f show other traumailc event, the Medical Examiner must be notified at				,	7	1	-								
	ss 1 and 2 of Heelth litem 27 I		Raymond F 20a. Method of Dispo		husba	20b. F	2948 Place of Dispo	LODES osition (Nan	ne of	Dove	. Rd.	Mt. A	20c. l	ocation - City o	1771 r Town, Star	te
2	ages nt of t: If If		1 🗆 Burial 2 5	Cremation 3 5	Removal from	State S	emetery, cre	matory or o	ıtnər piaci	9)	_		1.	field,		-
Baltimore	permit. Pages Depertment of I Important: If Its any Injury or o		21. Signature of Euro													
Ba	Depertment of the population o		Som	12/	911/11									n Funer		
	Physician		Immediate Cruse (F	failure. List only final	plicati s that cone use on e	aused the deat	h. Do not en	ter the mod	e of dying	g, such as	cardiac	Rd. V	VINT arrest,	ield, i	Approx	784 imate I Between and Death
	/Medical Examiner		esulting in death)		Due to	(or as a conseq										
	LAdiminei	L	Sequentially list con	ditions,	b. Se	2129										
	sit s	Examiner	Sequentially list con cause. Enter Under Cause (Disease or in	lying	Due to	as a conseq	uence of									
	ate be executed hysician and he burial-transit	xan	that initiated events resulting in death) Li		c. Due to	or as a conseq	uence of):		_							
760,	be e ician buria	calE				,										
687	phys phys s the				_ d.											
.O. Box (	ires that the death certifica signed by the ettending ph d be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	1 Live b	come of pregna birth 2 Feta nant at time of d	Ideath 3[	□Ectopic pr □ Other (sp					(A)	23d. Date of de Month	elivery Day	Year
Δ,	The law requires that the death ste has been signed by the etter bage 2 should be detached for u	d by Ph	Part II. Other signific	cant conditions c	ontributing to de	eath but not res	ulting in the u	inderlying c	ause give	n in Part I.			tobacco Yes 2	use contribute		of death?
50	w requir been si should	ete										24a. Was	-			
al Records,		Comp										auto	opsy ormed?	prior to death?	completion	ngs available of cause of
Z.	Physicien: this certific ral director,	B	25. Was case referre examiner?	/ '	Hospital:				Othe			Check only				
of	<b>o</b> - 'a	٠ <u>.</u>	1 ☐ Yes 2 ☑ ✓		28a. Date		ER/Outpaties 28b. Time of		/A	4 🗆 Nu	1	me 5 Res 28d. Describe		ther (Sp	ecity)	spice
L <sub>O</sub>	ding h. After fune	to S	1 Natural	5 Pending investigation	(Mon	th, Day Year)	Injury	M	Bc. Injury Work	? (es 2 🗆 1		zad. Describe	now inji	ary occurred		•
isi	Attending r death.	Ica	2 Accident 3 Suicide	6 Could not be		of Injury - At he	ome farm st					28f Location	/Street s	ind Number or F	Pural Pouto	Alumbar
Division of Vital	after Dire	erti	4  Homicide	determined	buildi	ng, etc. (Specif	y)	ieet, raciory	, onice			City or To	wn, Sta	te)	urar Houte	rvurnoer,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: . Completely filled in by the f	Medical Certification;	29a. Certifier (Check only one)	1 Certifying Ph	niner: On the b	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred evestigation	at the tim	e, date an inion, dea	d place, th occurr	and due to the	cause(	s) and manner and place, and du	is stated. le to the cau	se(s)
	ompl	Me	29b. Signature and t	itle of certifier	`			290	. License	number			29d. D	ate signed (Mor	הth. Day, Ye	ar)
			· DO	+11	)	n P/10		1	M	115	97		. 1	22 10-		
,	( n )	1	30 Name and addre	ss of person who	completed caus	se of death (Item	n 23a) (Tyna	Print)		UYU	( )		- 17	2017		
-5	LV		noharl hi	ic mi	555	South	Carte	40.1	264	1,0	Stu	victor	iN	1) 2115	7	
	Sta	ate	31 Date filed (Month	n, Day, Year)		legistrar's Signa			6			10010F	111			
1	Regist	rar		JAN 22	2007	A Show	As of	perk								

			For 1 - State Registrar	State of M		d / Depa		of He	alth and	d Mental Hy		n 7	01293
			Decedent's Name (First, Middle, L.	ast)						2. Date of D	ath	0 /	3. Time of Death
	Physici		Edward A.	Waller						JANU	Day 7	Year	556 AM
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)	)		4b. City, To	own, or Lo	cation of De			nty of Death	
1			St. Thomas More				Hya	ttsv	ille		Prin	ice Ge	orges
	Funeral		Social Security Number     6.	. 35		ast birthday)	If Under 1 Months 1		f Under 24 H	In. 8. Date of Bi	rth ay, Year) 9, 1934	9. Birth	place (State or Foreign
	Director		226-42-0648	163 M 2 L F	72	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Feb. 1	9, 1934	Vir	ginia
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	r, Town or Lo	cation						10d. Inside City Limits
	/ sho	5	DC			lashing							1 A Yes 2 □ No
	28e-	Director	10e. Street and Number		, ,	asiitii	10f. Zip C	nde			10g. Citizen o	of What Cou	ntry?
	Sa or	ā	748 Oglethorpe	St NE				2001	1	;		USA	,
	death with the Maryland rns 23a or 28e-f show r novat be notified at	Funerai	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V				(Specify Yes or Nuerto Rican, etc.)		ace - Ameri	
	or ite	F	1 ☐ Never Married 2 ☒ Married	Armed Forces						ierto Rican, etc.)		lack, White,	etc.
93	hours after tural', or ite	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 25	XINO S	Specify:		Spe	city: B1.	ack
5-0	72	Completed	15. Decedent's (Specify only highest g	Education rade completed)		16a. Deced	dent's Usual ( kind of work DO NOT use	Occupation done duri	on ing most of	working	16b. Kind of	Business/In	dustry
21	within and the second	idu	Elementary/Secondary (0-12)	College (1-4or	5+)					ŭ	g.	57	1.
2	filed v Hygie other t		9th 17. Father's Name (First, Middle, Las			Wareh	nousema		2 Mathada I	Name (First, Middle		r Ven	ding
and	ntat hed of	Be	Will Waller	117						Fitzger.		ame)	
Ž	2 should be n and Mentat is marked reumatic ev	2	19a. Informant's Name/Relationship	(Tyne Print)		19h Mailir	o Address /			Rural Route Numb		um Stato Zir	Code
Maryland 21215-0036	ges 1 and 2 should nt of Health and Men If Item 27 is marke or other treumatic		Juanita D. Wall				gletho				-		
ō,	of Health item 27 i		20a. Method of Disposition	er/wire	20b. P	lace of Dispo			SL NE	Washin Date	20c. Locatio		
JO T	Pages rtment of rtent: If i rtent: or right.  I i rent: i		1 XBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		,				1	16 2007	T	1 MD	
Baltimore,	= 0 O = 0		21. Signature of Funeral Service Lice	<u> </u>	n ria	ryland			_	16-2007 al Home,	Laure	I, MD.	
B	Depermil Deper impor eny ir		> Jupma	nshall						al Home, . Washi		DC 200	011
			23a. Part . Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death							BG 200	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	y one cause on each									Onset and Death
	/Medical		resulting in death)	a. Due to (or as		uence of):	-	-	2071	hapus			9
	Examiner		Conventingly lies and disings	b									
0	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):	·						
B.	nd	Examiner	that initiated events	c									
,097	be executed sicien and burial-transit	EX	resulting in death) Last	Due to (or as	s a consequ	ience of):							
876	9 % 0	dicai	•	d			-						
x 68	The law requires that the death certifica te has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of preama	nev							
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic preg					Date of delive Month	ery Day Year
P.O.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	it time of de	JE 3	2 Other (Spec	"y/					
σ.	that the de led by the a detached t	by Ph	Part II. Other significant conditions	contributing to death t	but not resu	ılting in the u	nderlying cau	se given i	in Part I.	23e. Did	tobacco use co	ontribute to t	he cause of death?
ds	n sign	Q P	Arteriordero	The Chad	LOVA	sala	- DN	eis	ee	1 🗆	Yes 2□No	3 🗆 Prob	ably 4 Onknown
Ö	w requir s been si should	jete	Atres Colons	Hatron	Thu	mho	1.40	m /.		24a. Was	an 24t	o. Were auto	ppsy findings available
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Vital Records,	10 TT	0	25. Was case referred to medical					20	6 Place of I	1 ☐ Yes Death (Check only	2 No	1 🗆 Yes	2   No
Ž		To B	examiner? 1 Tes 2 No	Hospital: 1 Inpati	ient 2 🗆	ER/Outpatien	t 3 DOA	Other:		g Home 5 ☐ Res		Other (Specif	(v)
J of			27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju	ury av Year)	28b. Time of Injury	280	: Injury at Work?	-		how injury occ		
<u>0</u>	Attending ir death. ector: After by the fune	atle	2 Accident investigati				М	1 TYes	s 2 No				
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of in	ijury - At ho tc. (Specify	me, farm, str	eet, factory, o	office		28f. Location (	Street and Nui wn, State)	mber or Rura	al Route Number,
Ω	urs af												
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	Physician: To the best aminer: On the basis of and manner st	t of my know of examinate	wledge, death ion and/or in	n occurred at vestigation, in	the time, my opini	date and pla ion, death o	ace, and due to the ccurred at the time,	date and place	manner as s e, and due to	tated. o the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and marrier si	ialeu.		_ 29c. L	icense n	umber		29d. Date sign	ned (Month,	Day, Year)
	F > F 5		1000	· Vos	1.1	(-/)	7 7	31	250	-	7.740	WAR	12003
-	a		30. Name and address of person wh	completed cause of	death (Item	23a) (Type.	Pript)	- , ;		A :	· VAN	, K.C.	Day, Year)  1 207  US 20781
	3		Paul A. DE	VORE N	W C	1203	tyve.	ens	burn	Rd Hy	attso	: 10 A	11/20781
	Sta		31. Date filed (Month, Day, Year)	32 Regist	rar's Signa	ure	ant 8						
-	Registr	ar	JAN 2 0 2	007	10 De	September 1	er like						

DHMH 17 Rev 1/2001

				For State	State of Ma	ryland / De		of Healtl	h and Me	ental Hyg	giene 0	7	01294
				Registrar  1. Decedent's Name (First, Middle, Last)			Cillicate	UI Dea		2. Date of Dea	ith		3. Time of Death
		Physicia	an	Alexander Gardiner	Allan					Month 01	07/2007	Year	1823 M
		/Medic		la. Facility Name (If not institution, give str			4b. City, To	own, or Locati	on of Death	01/	4c. County	of Death	1010
		Examini	e i	Atlantic General H	ospital		Ber	lin			Worce	ster	
	F	uneral		5. Social Security Number 6. Sex		(In yrs. last birthd	ay) If Under 1	Year If Un	rs Min.	8. Date of Birth (Month, Day	, Year)	9. Birth	place (State or Foreign
		irector		207-12-0394	W 2U F	83 Yrs				04/20/1	1923		VA
	and	A 10		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location						I0d. Inside City Limits
	Mary	-f ehc	ţō	MD Worcester		Ocean C	ity						XXYes 2 □ No
	the the	or 28a	irec	10e. Street and Number		•	10f. Zip C	ode			10g. Citizen of V	hat Cou	ntry?
	É Wi	23a or 28a-f ehow ust be notified at	Funeral Director	11616 Shipwreck Ro	ad		218				USA		
	r dea	teme E. T.	nue	Tr. Maritar Clares	. Was Decedent E Armed Forces?		<ol> <li>Was Deceder If Yes, specify</li> </ol>	nt of Hispanic y Cuban, Mex	Origin? (Specican, Puerto F	cify Yes or No- Rican, etc.)	14. Race Blace	e - Ameri k, White,	can Indian, etc.
	36 safte	r, or l	by F	1 ☐ Never Married	1 XYes 2 N If Yes, Give Year or Dates:		1□Yes 💥	XNo Spec	cify:		Specify	Whi	te
	<b>6</b> 5		ted	15. Decedent's Educa	ition	16a. De	cedent's Usual I	Decupation			16b. Kind of Bu	siness/In	dustry
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	24 William	other then	Be Completed		2	Uwne	er/Opera		ethada Nama	/First Middle	Propane Maiden Sumam		ppliance
	Maryland 21215-0036 to 2 should be filed within 72 hours after death with the Maryland	od ott	Be	17. Father's Name (First, Middle, Last)  A. T. C. Allan						n Gardi		θ/	
	Tould by St.	and Mental te marked o reumatic eve	ဥ	19a. Informant's Name/Relationship (Type	a. Print)	19b. N	lailing Address (S					State, Zij	o Code)
	Ma Id 2 s	r Health and Mental Hyg Item 27 te marked othe other treumatic event,		Nancy Allan (spou			6 Shipw				CARD-COOK		
	s 1 ac	Item 27 other tr		20a. Method of Disposition	•	20b. Place of D	isposition (Name crematory or other	of er place)		ate	20c. Location -	City or T	own, State
	Baltimore,	Department of a limportant: If Ite any Injury or o one one.		1 ☐ Burial 2 A Cremation 3 ☐ Re. 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		enlopen	Crem.			Frankfo		DE
	alti	pparts ports ny Inju		21. Signature of Funeral Service Licensee	12						neral H		
	00 8.0	2 = 9 9		/ Pacqueline	1 Day	alty					MD 218	11	Approximate
				23a. Part1. Enter the disease, or complete shock, or heartfailure. List only one Immediate Cause (Final	cause on each lin	e. deam.	enter the mode	or aying, sucr	i as cardiac o	r respiratory ar	rest,		Interval Between Onset and Death
		ysician Medical		disease or condition resulting in death)	- Due to (or as	a consequence (f)	1515			THE .			
		aminer			Due to (or as a	a consequence in							
		-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury	Due to (or as a	a consequence of)							
	ecuted	transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D								
73	. Box 68760, death certificate be executed	sicien and burial-transit	cai Ex	resulting in death, East	Due to (or as a	a consequence of)							
-	687	physis s the		d.									
3	Box (	ettending physics as the	an/Med	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome		о Пе				23d. Da	e of deliv	ery
14/03	Geath	e ette ed for	ਹ	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at	2 ☐ Fetal death time of death	3 ☐Ectopic prec 5 ☐ Other (spec				Мо	nth	Day Year
>	P.O	ed by the detached	Physi	9 Unknown	9□ Unknown	2							
1/20/1923 to		s been signed to should be det	ρ	Part I/Other significant conditions cont	ributing to death bu	ut not resulting in the	ne underlying cau	use given in P	art I.	239. Dia to			the cause of death?
162	Orc requi	hould	eted	100111111	10000	C							
120	Records,	has 3	Completed								rmed?	prior to co death?	opsy findings available empletion of cause of
3-		ificate or, pa	ပို	25. Was case referred to medical	-			26 F	Place of Death	1 ☐ Yes	_	I∐Yes	2□ No
<	of Vita	is cert direct	ToB	examiner?	ospital: 1 Inpatie	nt 2 ER/Outp	atient 3 DOA	Other			dence 6 □Oth	er (Speci	fy)
Allan	n of	ter th		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injur (Month, Da)	y 28b. Tin	ne of 28	c. Injury at Work?	2	28d. Describe h	now injury occur	red	
6. A	Siol	eath.	catic	2 Accident investigation 3 Suicide 6 Could not be			М	1 Tes					
	Division	Direct Direct in by	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm c. (Specify)	s, street, factory,	office		City or Tov		er or Hui	al Route Number,
	Division the Hospital or Attending	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physi	cien: To the best of	of my knowledge, o	death occurred at	t the time, dat	e and place. a	and due to the	cause(s) and ma	nner as	stated.
lexar 267	H.	24 h	Medical	(Check only 2 Medical Examin one)		examination and/							
A	70 th	within 2 To the complet	M	29b. Signature and title of certifier	A -		29c.	License numl	ber		29d. Date signe	d (Month	Day, Year)
	•			· Sulva	Mel	)		645	22		1/81	07	,
	Ω	3A5+1		30 Name and address of person who con	npleted cause of d	eath (Item 23a) (T	pe, Print)	1	Sodin	MA	718	11	
3		_	ato.	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	The season	/ //	KI WI	1.41	010	U	
		Sta Registr		JAN 0 9 200	_	w St.	Markey						

		For State Registrer 5, 8, 9 per  1. Decedent's Name (First, Middle, L	ast)	2 011	110			2. Date of Deat			3. Time of Death
Physic		Troy Wil	lson i	Ashcraf	t			Month Januar	Day	Year 2007	8:10 M
/Med Exami		4a. Facility Name (If not institution, g	ive street and number	)	4b. C	ty, Town, or L	ocation of Death	Junual	4c. Count		
		601 North Park	Drive		Sa	alisbur	У		Wice	omico	
Funera Directo		214-12-8868	Sex 7. A	ge (In yrs. last b 83	birthday) If Un Monti		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	10–18–1 Year) <del>1923</del> –	991 9 other County	olace (State or Foreign htry) NC land
A H		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location					1	0d. Inside City Limits
f show	ō	Maryland Wicom	ico	Salis	bury						1 XYes 2 No
r 28	Irec	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of	What Coun	ntry?
23a o	a D	601 North Park	Drive			21804			USA		
E III	Iner	11. Marital Status	12. Was Decedent Armed Forces		13. Was De	cedent of Hisp	anic Origin? (Spe Mexican, Puerto	cify Yes or No-		ce - Americ	
Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28s-1 shov say hjury or other traumatic event, the Medical Examinal must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	No			Specify:	ritodii, oto.,	Specif		hite
natu deal	eted	15. Decedent's 1 (Specify only highest g		16	ia. Decedent's U	sual Occupation	on ing most of workii	20	16b. Kind of B	usiness/Inc	dustry
Man a	d d	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	use retired)	ing most of working	<i>'</i> g			
the state		12 17. Father's Name (First, Middle, Las			Owner				Paper		any
ed of	o Be	Troy Sydney Asho	*			11	8. Mother's Name Clara De			.,	
h and Mental Hygiene. 7 Is marked other then " fraumatic event, the Mac	F	19a. Informant's Name/Relationship		10	9h Mailing Addr	ass (Street and	d Number or Rura				Codal
27 le		Steve Ashcraft/	son				n Dr., Sa				(2006)
f Heelth Item 27 other tr		20a. Method of Disposition		como	of Disposition (/	Name of	D	ate	20c. Location	City or To	wn, State
nt: If ry or	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Speed		t Wicon	tery, crematory of NICO Mem	orial	1/5/0	07	Salisb	ury,	MD
Department of Importent: If It eny Injury or o once.		21. Signatule St. Euneral Service Life	ensee	102.	22HOT	and Address		lome Pro	fession	al As	ssociation
N TOTAL		23 Par 1. Enter the disease, or con	mplications that cause	d ne death. Do					-	, 2100	Approximate
ysician		strock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	y one cause of each l	ine			INOMA	OF LU			Interval Between Onset and Death
Medical aminer		103utting in obatin)	Due to (or as	a consequence	e of):						
	- i	Sequentially list conditions,	b. Due to for as	a cursequenc	e of)						
Insit	를	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	33213 (31 33		G 01).						
sicien end burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	e of):						
nysicien he burial	cal		d								
as th	led				1977						
by the attending phateched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea	th 3 ☐Ectopic 5 ☐ Other	pregnancy (specify)				te of delive inth	ory Day Year
B 8	by Pr	Part II. Other significant conditions	contributing to death t	out not resulting	in the underlyin	g cause given	in Part I.	23e. Did tob	acco use cont	ribute to th	e cause of death?
been sign should be	ed b		···					1 🖸 Ye	s 2 🗆 No	3 Proba	ably 4 Unknown
s bee	Completed							24a. Was a	n 24b.	Were autor	psy findings available
te has	E			·		·		autops	ned2	prior to con death?	npletion of cause of
certificete ha	Be C	25. Was case referred to medical				2	6. Place of Death	1 Yes 2		1 ☐ Yes	2 LI NO
this ceral direct	10	examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/C	Outpatient 3	T O11	4 Nursing Hon			er (Specify	<i>(</i> )
0		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b	. Time of Injury	28c. Injury at Work?		8d. Describe ho			<u> </u>
death. ctor: Ali y the fur	catle	2 Accident investigation	on		. , м		2 □No				
Dir.	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 289. Place of in	jury - At home, tc. <i>(Specify)</i>	farm, street, fact	ory, office	2	8f. Location (Sti City or Town	reet and Numb , State)	er or Rural	l Route Number,
within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying P (Check only one)	Physician: To the best miner: On the basis of and manner st	or examination a	ge death decum and/or investigati	ed at the time, on, in my opini	date and place, a ion, death occurre	nd due to the ea od at the time, da	tuse(s) and ma	n her as sta and due to	ated. the cause(s)
C E TO	₩	29b. Signature and title of certifier			2	9c. License n	umber	29	9d. Date signe	d (Month, L	Day, Year)
o the	1	July Naviusor	2			0051	259		-		
To the Fi						V V 21	111	J	CIPILAMA	4 4 1	1001
L C C C C C C C C C C C C C C C C C C C	1		completed cause of	death (Item 23a	) (Type, Print)		1		anuar	7	
		30. Name and address of person who			(Type, Print)		4.	BURY	MD 21.	804	

State Registrar 31. Date filed (Month, Day, Year) JAN 08 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

HNUPAMA



29c. License number

DIVISION 51.

29d. Date signed (Month, Day, Year) 12007

			Please  1 - Stete Registrer	State of Maryland /	Depa		Health ar		ntal Hygie	•	le.	01007
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las LEONIA ATKI)  4a. Facility Name (If not institution, give Holy Cross Hosp	NS street and number)		4b. City, Tow	n, or Location of I	Death	Date of Death Month	Day 1 200 4c. County o		3. Time or Death  12:50 P M  nery
	uneral rector		Social Security Number 6. S		irthday) Yrs.	If Under 1 Ye Months Da	ar If Under 24		Date of Birth (Month, Day, ) Aug. 13	rear)	Count	ace (State or Foreign try) INESSEE
e Maryland	Ba-f show	Director	10a. State 10b. County Md. Monto	gomery San		Spring						0d. Inside City Limits 1 ☐ Yes 2 📉 No
with th	3a or 2	i Dire	10e. Street and Number 18611 Brooke Ro	ad		10f. Zip Cod	e 2086	0	100	g. Citizen of Wi United		
urs after deetl	Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 図 No If Yes, Give Year or Dates:		Vas Decedent Yes, specify C	of Hispanic Origin Luban, Mexican, F No Specify:	n? (Speci Puerto Ri	y Yes or No- can, etc.)	14. Race Black Specify:	White, e	
ithin 72 hot ne.	han "natura s Medical E	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give . life. [	OO NOT use re	ne during most o tired)	f working	16	Sb. Kind of Bus		
Id be filed v	rked other tilc event. In	To Be Co	12 17. Father's Name (First, Middle, Last) James D. Wa	tson	NU	rses A	-		First, Middle, Ma	Nursi		ome
end 2 shou	n 27 le ma ner trauma		19a. Informant's Name/Relationship (7 Frank J. Atkins	/ Husband	1861	.1 Broo	se Road,	San	dy Spri	ng, Md.	2	0860
mit. Pages 1	tent: If iter jury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State Fores	t Oa	sition (Name or natory or other ik Ceme	tery	Dat 1/6/	07	Gaither		
Decariit	eny in		21. Signature of Funeral Service Licen	-Barber			dress of Facility Barber ox 5038,				208	82
be executed W	edical miner private p	sai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the control of the control of the control of the cause or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardio Pula  Due to (or as a consequence  End Stage  Due to (or as a consequence  Stroke  Due to (or as a consequence  Stroke  Due to (or as a consequence  Stroke  Sepsis	mona of): Rena of):	ry Arre	est	rdiac or r	espiratory arres	st,		Approximate Interval Between Onset and Death
The law requires thet the death certificate	been signed by the attending phy should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregna Other (specify				23d. Date Mont		ry Day Year
w requires that	n signed by uld be deta	þ	Part II. Other significant conditions of	ontributing to death but not resulting	in the ur	nderlying cause	given in Part I.					e cause of death?
The law re	icate has bee ; page 2 sho	Completed							24a. Was an autopsy performe 1 Yes 2	ed? pr	or to com ath?	psy findings available apletion of cause of
ysiciar	is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ☐ ER/O	utpatien	t 3 DOA	0.1		Check only one) 5 ☐ Residen		(Specify	)
Attending Ph	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	27. Manner of Death 1 ™ Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	(Month, Day Year)	Time of Injury	М	njuryat Work? I∐Yes 2∐No	28	d. Describe how	injury occurre	d	
pltal or At	eral Directilled in by		4 Homicide determined	building, etc. (Specify)					f. Location (Stre City or Town,	State)		
he Hos	the Fun pletely	edical	(Check only 2 Medical Exam	ysicien: To the best of my knowledg tiner: On the basis of examination a and manner stated.	nd/or inv	restigation, in n	e time, date and i	occurred	at the time, dat	e and place, ar	ner as sta nd due to	the cause(s)
ToT	Too	Σ	29b. Signature and title of certifier	Themme		D	ense number 0065069			d. Date signed January		
5	>		30. Name and address of person who sirak Lemma, M.		(Type,	Print) Glen Ro	ad, Silv	er S	pring,	Md. 20	910	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 0 4 201	37/Registrar's Signature	dos	well .						

Physician /Medical Examiner	Decedent's Name (First, Middle, Last,     RONALD H. BAKER	)				
	4a. Facility Name (If not institution, give PUNINSUM REQUENTED IN	Medical Control	4b. City, Town, or	alusury	Day Year 1007 4c. County of Dea HICHM	ith
Funeral Director	5. Social Security Number 6. Sec. 231–58–3871	7. Age (In yrs. Ia XM 2 F 61	st birthday) If Under 1 Year  Yrs. Months Days	Hours Min. 8. Date of (Month, 06/	Birth Day, Year) 9. Bir 14/45	thplace (State or Foreign ountry) VA
me 23a or 28a-f show rmust be rotified at nerai Director	VA 10b. County Accomac		Town or Location arksley			10d. Inside City Limits 1
r teme 23a or 28a-f e charmant be notified Funeral Director	10e. Street and Number 23496 Leslie Trent	t Rd.	10f. Zip Code 23421	l	10g. Citizen of What Co	ountry?
à à	11. Marital Status  1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1966—		spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Ame Black, White	
t, tra Madical E	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	uring most of working	16b. Kind of Business	,
To Be Co	17. Father's Name (First, Middle, Last)  Johnson Baker	<u> </u>	Truck Drive	er 18. Mother's Name (First, Mid Marcella E	ŕ	e
27 is ma or trauma	19a. Informant's Name/Relationship (Ty Barbara Ames, Frie		19b. Mailing Address (Street a P.O. Box 292	nd Number or Rural Route Nu	mber, City or Town, State, .	Zip Code)
ury or oth	20a. Method of Disposition  12 Burial 2 ☐ Cremation 3 ☐ P  4 ☐ Donation 5 ☐ Other (Specify)		ace of Disposition (Name of metery, crematory or other place arton Cemetery		20c. Location - City or Parksley,	
Import any inj once.	21 Signature of Funeral Removed 1992 224. Part1. Enter the disease, or compleshock, or heart failure. List only or	Ope h.		łumbles Funera	1 Co.,. Accor	
attending physician and toruse as the burial-transit and particle in the properties of the properties	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to for as a consequence.  Renal Full  Due to (or as a consequence).	u へを nnaa at):			Onset and Death
etached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the second o	death 3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
<u>ه</u>	Parll. Other significant conditions cor	ntributing to death but not result	ting in the underlying cause give		id tobacco use contribute to	
ompi	25. Was case referred to medical			pe 1 □ Ye	enformed? death?	utopsy findings available completion of cause of 2 No
Atter this funeral d	examiner?	28a. Date of Injury (Month, Day Year)	ne, farm, street, factory, office	at ? 28d. Descril ? 28f. Locatio	1	
To the Funerei Director: completely filled in by the Medical Certificat	29a. Certifier 1 Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	ledge death occurred at the time on and/or investigation, in my opi	e date and place, and due to t inion, death occurred at the tin	the causo(s) and maimor as ne, date and place, and due	s stated. e to the cause(s)
	29b. Signature and title of Zertifier		29c. License	number	29d. Date signed (Mont.	h, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BRADLEY JANUARY 2007 3 4:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLINTON REHAB CENTER CLINTON PRINCE GEORGE'S 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours 223-52-9059 Director 68 APRIL 22,1938 VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD PRINCE GEORGE HYATTSVILLE 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itema 23a or 8204 ALLENDALE TERRACE 20785 death v U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after 1 ☐ Yes 2 ② No II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. Specify: BLACK þ 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) 9th ADMINISTRATIVE ASSISTANT GOVERNMENT filed v Hygie other permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othk any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM PEOPLES SR. DOROTHY MAE LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCELIA BRADLEY/DAUGHTER 8204 ALLENDALE TERRACE HYATTSVILLE, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 101-04-2007 RIVERDALE, MD J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol) Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death Day 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 as been sig 1 ☐ Yes 2 ☐ No 3 Probably 4 Thunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 ☐ Yes 2 💹 No 1 🗆 Inpatient Other: 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35206 JANUARY 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM T. TANNER MD 11701 LIVINGSTON ROAD # 101 FT. WASHINGTON, MARYLAND 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signati State JAN 0 4 2007 Registrar

		1	For State Registrar	State of Ma	ryland /		artment of H tificate of L			giene 0	07	01300
	Physicia		1. Decedent's Name (First, Middle, Last) FRANCES		BROWI	N.			2. Date of De	_	007	3. Time of Death 6:27 P M
	/Medic Examin		In Title 5	street and number)	Ditoili	•	4b. City, Town, or	Location of Dea		4c. County		0.27
	Examin	eı	Collingswood Nurs		ab.Cent	ter	Rockvi	lle		Mon	tgome	ery
	Funeral Director		5. Social Security Number 6. Sex 218-24-2415	7. Age	(In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mii		th ly, Year) 3 1922	Coun	place (State or Foreign htry) ryland
	pu *	-	Usual Residence of Decedent  10a, State 10b, County		10c. City, To	own or Lo	cation				1	I0d. Inside City Limits
	Maryl.	ğ	Md. Montgor	mery	Roo	ckvil	lle					1XYes 2□No
	n the	Irec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a c 23a c	aiD	730 Grandin Avenue					20850		United		
336	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 「Yes 2XN ff Yes, Give Year or Dates:			Was Decedent of Hi fYes, specify Cuba 1□Yes 2⊠ No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		ck, White,	ean Indian, etc. Vhite
20	72 hor	ted	15. Decedent's Edu (Specify only highest grade		16	(Give	dent's Usual Occupa	durina most of w	vorking	16b. Kind of B	usiness/In	dustry
2	vithin ne. han "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT use retired emaker	")		Own H	ome	
Q Q	filed v Hygie other t		10 17. Father's Name (First, Middle, Last)	0				18. Mother's N	lame (First, Middle	, Maiden Surnar	ne)	
lan	ould be Mental arked o	To Be	John Marshall	Parker				Fanni	e Ofie	d		
lary	2 should and Men le marke sumatic		19a. Informant's Name/Relationship (Ty				ng Address (Street a					20850
e, r	1 and Health em 27 ther tr		Carlene A. Mills ,	Daughter	20b. Place	of Dispo	sition (Name of		Date	20c. Location		
nor	ages ant of at: If It		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		1	-	matory`or other plac Litan Cre	1	/3/07	Alexa	ndria	a, Va.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tra 9000.		21. Signature of Funeral Service Licens  **Through Through Thr		erk	-	Name and Addres Muriel H	ss of Facility Barbe	r Funeral	Home		20882
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the death. D	o not ent	P. O. Be er the mode of dyin	g, such as card	, Laytons iac or respiratory a	rrest,	Ma.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A Cu	F. A	Lyr	Carchia	I'ml.	aceto			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	ce of):		+	0.1			
		ьг	Sequentially list conditions,	Due to (or as	a consequence	ce of):	navy H	1 ery	D120	200		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
Ö,	cate be executed physicien and the burial-transit	Exe	resulting in death) Last	Due to (or as	a consequen	ce of):					Î	
8760,	cate b physic the b	dical		d								
P.O. Box 6	ne death certifi the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	23c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetaf de	ath 3[	⊒Ectopic pregnancy ∃ Other (specify)				ate of delive	ery Day Year
	quires that II n signed by uld be detac	۾	Part II. Other significant conditions co	ntributing to death bu	ut not resultin	ig in the u	inderlying cause giv	en in Part I.		obacco use con Yes 2 ☐ No	tribute to t	he cause of death? bably 4 Dunknown
Vital Records,		Completed							24a. Was auto perf 1  Yes		Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
Vita	ilcian: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	05 11	Death (Check only			
of	Physical direction	- T	1 Yes 2 No	28a. Date of Inju	y 28	Outpatie b. Time o	II 3L DUA	4 Nursing	g Home 5 Res	how injury occur		(y)
ion	nding lath. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	Year)	Injury		k? Yes 2 □No				
Division of	Hoepital or Attending Physicien: 4 hours after death. Funeral Director: After this certification by the funeral director, tely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnju building, etc		, farm, st	reet, factory, office		28f. Location City or To	Street and Num wn, State)	ber or Rura	al Route Number,
	To the Hoepital or Attention 24 hours after de To the Funeral Directo completely filled in by the	Medical (		sician: To the best of the basis of and manner sta	examination							
	To the vithin 2 To the complex	Ž	29b. Signature and title of confiler	- 100	Δ Δ -		29c. Licens	1	20	29d. Date signe	d (Month.	Day, Year)
,	1		1 3> tasayy	2000	/V((	)		0624	5 >	115	1 20	
			30. Name and address of person who co	PHYPP	eath (Item 23 9 71 9 ar's Signature	5 N	leoli(v)	enter 1	), Ro.	ckvil	1e,M	020850
	Sta Regist		JAN 0 4 20		w K	A	rade					

Jan. 1, 2007

			For		State of M	aryland				lealth and N	lental Hy	/giene	200	7 0	1120
			- State Registrar				Ce	rtifica	te of	Death		Reg. No.	200	1	
	- Physici	an	Decedent's Name (First,  CARL	Middle, Last		BELL					2. Date of D Month	eath Day	/ Ye		ime of Death
	/Medic		CARL	ANTON	ITO I	بسبعج					Jan,		007		37 A M
	Examir	er	4a. Facility Name (If not ins		,			4b. City	, Town, o	r Location of Death		4c.	County of D	eath	
		24	Shady Gro						ockvi		To 5 : 45		ontgan	ery	
	Funeral		5. Social Security Number	6. Se	X 7. Ag ]M 2□F	ge ( <i>In yrs. la</i> 46	ast birthday) Yrs.	Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Apr. 2	irth 1 <sup>3y,</sup> <b>Y6</b> 3E	0 9.	Birthplace (: Country <b>lary La</b>	State or Foreign
	Director	-	215-78-7934 Usual Residence of Deced			40					ADL . Z	,100	0 1	iai y ia	
	land ow			County		10c. City	, Town or Lo	ocation						10d. In:	side City Limits
	Many f sh ied a	ō	MID M	ontgom	ery		Germ	anto	wn					1 (	<b>X</b> Yes 2 □ No
	the 28a- notif	rec	10e. Street and Number					10f. Z	ip Code	-		10g. Cit	izen of What	Country?	
	3a ol		19325 Runn	ing Ce	dar Court	-			208	276			U.S.A.		
	ms 2	Funeral Director	11. Marital Status	119 00	12. Was Decedent	Ever in U.S	3. 13.	Was Dec		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N		14. Race - A	merican Ind	lian,
G	after or ite		Never Married 2	☐ Married	Armed Forces:						Hican, etc.)			Vhite, etc.	
03	ours arrangements	<u>P</u>	3 ☐ Widowed 4 ☐ Di	vorced	If Yes, Give Year or Dates:			1 ☐ Yes	2LXN0	Specify:			Specify:	Blac	k
2-0	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	Completed	15. De	ecedent's Edu	ucation le completed)		16a. Dece	dent's Us	ual Occup	ation during most of work	kina		ind of Busine		
2	ithin nan "	du	Elementary/Secondary (		College (1-4or	5+)			use retired river	during most of work d)	9		State dminis		
Maryland 21215-0036	be filed within 72 hours after death with the Marylan tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ខ្ញ	10th					<u> </u>	TTACT		/m:			LIALL	
P I	uld be fil fental H rked ott	Be	17. Father's Name (First, I	-						18. Mother's Nam	•		Surname)		
yla	should be ind Mental s marked o	은	Harold M								Jane E				
Nai	12 sh hand risin traun		19a. Informant's Name/Re Shamea Bell		•		1	-		and Number or Ru					)
e,	ss 1 and 2 should of Health and Mer them 27 is marker other traumatic		20a. Method of Disposition		11CEL	20h Pi				Cedar C	Date		cation - City		toto
Baltimore,	Pages nent of H ant: If Ite		1 X Burial 2 ☐ Crem	nation 3 🗆 I		· I _	ace of Disperent						·		
'≓	t. Pa rtmer rtant:		4 □ Donation 5 □ O		- /	Bro	ooke G			1/6/			thersb		
Bal	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral S	service Licens	•	101				ss of Facility Sno					
			23a Parti Enter the disc	Sea or comp	lications that cause	d the death				shington s			e, MD		oximate
			23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final	e. List only o							or respiratory	arrest,		Inter	val Between et and Death
	Physician /Medical		disease or condition resulting in death)	-	a		Pros	tate	Canc	er					
ď	Examiner			- (	Due to (or as		ence of): 11 Fai	1,,,,,							
ō		<u>.</u>	Sequentially list conditions	3,	b. Due to for a			Ture							
	ted nsit	Examiner	Sequentially list conditions if any, leading to inflied a cause. Enter Underlying Cause (Disease or injury	· <	Anemi		,								
	icate be executed physician and s the burial-transit	Xar	that initiated events resulting in death) Last		c Due to (or as		ience of):							_	
68760,	siciar burit	<u>=</u>			d										
289		edical			d										
Вох	leath certifi attending   I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, outcome								23d. Date of	delivery	
m	death a atte	icia	in the past 12 month 1 ☐ Yes 2 ☐ No		1□Live birth 4□Pregnant a			_lEctopic _l Other (	pregnanc specify) _	у			Month	Day	Year
0	that the de ned by the a	hys	9 Unknown		9□ Unknown							1			
Д,	s thai	by P	Part II. Other significant of	conditions co	ontributing to death	but not resu	liting in the u	ınderlying	cause giv	en in Part I.	23e. Did	tobacco	use contribu	te to the cau	ise of death?
rds	quires n sign uld be										1	Yes 2	<b>₹</b> No 3 [	Probably	4 □Unknown
Records,	The law requires that the death certite has been signed by the attending tage 2 should be detached for use a	Completed									24a. Wa		24b. Wer	e autopsy fir	ndings available
Re	The lav	HC.									aut per	opsy formed? 2 ☐ No	prior deat	h?	on of cause of
Vital		ပိ	25. Was case referred to	medical						26. Place of Dea				Yes 2. ZAN	NO
5	Physiclan: this certific	0 8	examiner? 1 ☐ Yes 2 🛣 No		Hospital: 1 1 Inpat	ient 2□	ER/Outpatie	nt 3 🗆 [	DOA Oth				6. □Other (	Specify)	
0			27. Manner of Death		28a. Date of Inj (Month, D	ury	28b. Time of	of	28c. Inju		28d. Describe			opoony)	
<u>ö</u>	Attending I r death. ector: After by the funer	atio	1 Accident 5 ☐	Pending investigation	(Monan, D	ay rear)	injury	М		Yes 2 □ No					
Division	I or Attend after death Director:	iţi	3 Suicide 6 ☐	Could not be determined	Zoe. Place of II	jury - At ho	me, farm, st	reet, facto	ory, office		28f. Location	(Street ar		r Rural Rou	te Number,
Ö	talor As after al Dire	Certification:			Denomy, e	(0,0001)	<u> </u>				Oily Of T	om, oran	-/		
	fo the Hospital of within 24 hours af To the Funeral Documental Documental Documental Documental Milled in	1			ysician: To the bes										221100(2)
	the H in 24 the Fi	Medical	one)		and manner s	tated.	aon ana/of f				med at the time	e, uate an	u piace, and	uue to the t	Jause(s)
	o time	Σ	29b. Signature and title of	certifie				2	9c. Licens	se number		29d. Da	ite signed (N	fonth, Day,	Year)

Petek Donmez, MD State

31. Date filed (Month, Day, Year)

11119 Rockville Pike #401 Rockville, MD 20852 32 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D62999

Registrar

		1	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H			iene	7 01302
	A) 300		Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	Physicia /Medic		Effie Christine Bee	son				1/6/20		10:20 A M
	Examin	_	4a. Facility Name (If not institution, give str				Location of Death	1	4c. County o	
40	. 4		Garrett County Memo			Oakla If Under 1 Year		8. Date of Birth	Garr	ett 9. Birthplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday) 91 Yrs.	Months Days	Hours Min.	1/7/191	Year)	Pennsylvania
***	Director		Usual Residence of Decedent							
	how		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	Ba-f s	cto	MD Garret	t	Oa	kland			0g. Citizen of W	
	with th	Dire	10e. Street and Number			10f. Zip Code		'	-	nat Country:
	sath v	erai	59 Sangamore Drive	. Was Decedent E	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		- American Indian,
36	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatin and Mental Hygiene. Int: if item 27 is marked other than "natural", or items 23e or 28e-f show int: if item 27 is marked other than "natural", or items 25e or 28e-f show int if item 27 is marked other than "natural".	by Funeral Director	1 Never Married 2 Married  3X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 K N If Yes, Give Year or Dates:	lo	lf Yes, specify Cuba 1 □ Yes 2 🙀 No	Specify:	to Rican, etc.)	Specify:	, White, etc. White
21215-0036	2 hou		15. Decedent's Educa		16a. Dece	dent's Usual Occup	pation	rking	16b. Kind of Bus	siness/Industry
212	hin 72 an "nu Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+) (Give	kind of work done DO NOT use retired	d) most of wo	/Killig		
21	ad wit	Соп	6th		Man	ager		(5)		Cafeteria
Maryland	I be file	Be	17. Father's Name (First, Middle, Last)  George Israel	Thiele	r		18. Mother's Nai	me (First, Middle, Reb	ecca •	Carey
Ž	should nd Me mark matic	၉	19a. Informant's Name/Relationship (Type			ng Address (Street	and Number or Ri	ural Route Numbe	r, City or Town, S	
<u>≅</u>	nd 2 sulth ar 27 is r trau		Mary Heamstead/ Day	ghter	59	Sangamore	e Dr., Oa	akland, M	D 21550	
re,	item item othe		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - (	Dity or Town, State
E	Page nent c int: if iry or		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Oakland O	emetery	1/9,	/2007	0akland	, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensis	1	2	2. Name and Addre	No. 1 Company of the Company			
	80 5 2 9		1 Stable 14	October				i St., Oa		MD 21550 Approximate
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cause on each III	16.	ter the mode of dyli	ig, such as cardia	c or respiratory arr	<b>C</b> 3(,	Interval Between Onset and Death
Sec. of	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		invuile					3 days
1	Examiner		1	Due to (or as	a consequence of):					
		Jer	Sequentially list conditions, it any, loading to item offsts cause. Enter Underlying	Due to (or as	a conse uence of:					
	be executed sicien and burial-transit	Examine	that initiated events c.							
, 0	e exe	EX	resulting in death) Last	Due to (or as	a consequence of):					
8760	ate he	dical	d.							
9 xo	leath certifica attending pl	Physician/Med	IF FEMALE: 23	c. If yes, outcome	of pregnancy				23d. Date	e of delivery
Bo	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		☐Ectopic pregnand ☐ Other (specify) _	У		Mor	oth Day Year
0	at the de by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		- 111000				_
σ,	es that igned to be det	by P	Part II. Other significant conditions conf	ributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.		_	ibute to the cause of death?
ord	v require been sig should b		multiintar	st d	em en tia			1 🗆 Y	es 2 No	3 Probably 4 Unknown
Records,	e law re has be je 2 sh	Completed	diupeter mel	litus	type to	10		24a. Was autop	sv p	Vere autopsy findings available into to completion of cause of
<u>=</u>		Con	Chronic renel	failure	stage	four			rmed? d 2 No 1	leath?  Yes 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		l Ot	han	ath Check only o		. (0 ( )
of	Phys this ral dil	٠ <u>.</u>	1 Yes 2 No	1 Minpatie		ant 3L DOA	4 Linuising	Home 5 Resid	now injury occurr	
o	After fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) Injury	Wo	ork? ]Yes 2∐No			
Division	Attending in death.	Certification:	3 Suicide 6 Could not be	28e. Place of In	jury - At home, farm, s	treet, factory, office		28f. Location (S City or Tox		er or Rural Route Number,
ō	s after	Sert	4 Homicide	building, ei	ic.*(Specify)			0.0, 0, 10.		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (	25a. Cartifur (Check only one) 2 Medical Examir	ician: To the best er: On the basis of and manner st	of my knowledge, dea of examination and/or i	ith occurred at the tinvestigation, in my	ima, data and plan opinion, death occ	curred at the time,	date and place, a	nner as stated. and due to the cause(s)
	o the ithin 2 o the xmple	Med	29b. Signature and title of certifier	and maillier st		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
			Addle Man	A Rasa	UD	10	0257	59	Tanuaru	6,2007
	10		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type	e, Print)	1			6,2007
			walter K. Naum	1 A	D. PU	Box 24	7 Au	cident p	10215	20
	St Regist	ate	31. Date filed (Month, Day, Year)	160	rar's Signature	Lock				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 10, January 2007 7:48 p.m. Earlene Freeman Burleson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary s

9. Birthplace (State or Foreign Country) Leonard town If Under . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗓 F 242-34-7864 Director 82 03/08/1924 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No Director Maryland | St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

1 14. Race - American Indian Funeral 23299 Jenifer Court 20650 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Be Completed by 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Technician Medical Supplies 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl Freeman Jessie Conlev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Hetmanski/Granddaughter 23299 Jenifer Court, Leonardtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 □ Donation 5 □ Other (Specify) Brinsf 1d-Echols Cre.1/11/2007 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home 21. Signature of Funeral Service Licensee Kyle S. Simons MO1206 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a to Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -\*:1. ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 2 □ No 1 Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 💆 Natural 5 ☐ Pending investigation 1 Yes 2 Accident after death 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier l 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

James P.

31. Date filed (Month Day, Year)

24035 Three Notch Road, Hollywood, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Registrar's Signature

Jarboe,

12

Amended Item 18b per F.D. 01/04/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Year **Physician** 9:15 A M 3 Jan Robert C. Brown /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Westminster Carrol] Carroll Hospital Center If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XIXM 2□F 82 212-20-3918 Director Aug 28, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐Yes 🎇 No Director Maryland Carroll Taylorsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be 21771 4519 Roop Rd. <u> United States</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩∏ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed by % Widowed 4 ☐ Divorced White "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10th London Fog Maintenance Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance of and Mental F Duvall Brown Margaret Smelzer Neilson 19a. Informant's Name/Relationship (Type. Print) 19b Mailing Address (Street and Number of Rural Route Number, City or Town, State-7ip Code)
2195 Feeser Rd. North, Taneytown, MD 21787 Pages 1 and 2 siment of Health an ant: If item 27 is 1 2195 Feeser Rd. North Toaney town, MD 21787
ace of Disposition (Name of 20c. Location - City or Town, State John M. Brown (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of I
Important: If ite
any Injury or ot 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Carroll Crematory 1/4/2007 4 Donation 5 Dother (Specify) Winfield, MD 22. Name and Address of Facility Kelly Durrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not the mode of thing struct yas contained by a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 7 csplrat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the buríal-transit Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the at d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 1 Yes 2 No P 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23443 1-3-07 1130 BALTIMORE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AYWALA W O 31. Date filed (Month, Day, State Registrar JAN 04

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	3a or	Funeral Director	504 Liberty Street			804		USA	,
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36	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2 N If Yes, Give Year or Dates:	•	1□Yes 2No	Specify:	,	Specify:	
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Baltimore,	iges 1 a nt of Hea : If Item or othe		20a. Method of Disposition  National 2 □ Cremation 3 □ Removal from State	cemet	of Disposition (Name of ery, crematory or other pla	ce)		20c. Location - City or	
Ħπ	permit. Pages 1 Department of F Important: If Ite any injury or ot	-	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Sarvice Licensée	Asbur	y U.M. Cemet	ess of Facility	/2007	Mt. Vernon	, Maryland
Ba	Departing any any once	1	Men Juline h MOO	0295	Hinman Fur	neral Home	ne. Pri	ncess_Anne	. MD 21853
T.	* 10		Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do	not enter the mode of dyi	ng, such as cardiac or	respiratory arr	rest,	Approximate Interval Between
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ion	Attending Pr r death. ector: After th by the funeral	atior	1 Xelatural 5 ☐ Pending (Month, Day 2 Accident investigation	Year)		rk?  Yes 2 □ No			
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	To the I within 2.	Me	29b. Signature and tifle of certifier		29c. Licens	se number	2	29d. Date signed (Mon	th, Day, Year)
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			30. Name and address of person who completed cause of de	eath (Item 23a	(Type, Print)	IT. r	Auch-	uno	1.1.1721
	Sta	ate	31. Date filed (Month, Day, Year)  32. Registra	ar's Signature	- conocp	VI. 01	1-1318	- July	, 0,0-1
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DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 0730AM 01 04 07 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Salsbury At the Hospice Wicomico Loastal If Under 1 Year | If Under 24 Hrs. Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number I **Funeral** Months Days 1 ☐ M 2 🔀 F 80 3, Director 062-20-0553 Jan. 1927 New York Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County show 1 ☑ Yes 2 ☐ No or items 23a or 28a-f sh aminer must be notified Director Delaware Sussex Delmar 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19940 U.S.A. 705 Lincoln Avenue Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: white ò 3 Widowed 4 Divorced 'natural', Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Branch Manager Bank 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Castellanos Mary Soimes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Philip J. Comba 705 Lincoln Avenue Delmar, DE 19940 (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Delaware Veterans Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Cemetery 22. Name and A dress of Facility Jan. 9, 2007 Millsboro, Delaware 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Short Funeral Home Delmar, DE 13 E. Grove Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTAT BREAST **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records. Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an page 2 autopsy perform 1∐ Yes or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No s after death. I Director: A in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

Registrar DHMH 17 Rev 1/2001

State

29h. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 0 5 2007

26266 egistrar's Signature D0058410

ARROWWOOD CT. SALISBURY MD 21801

		For State	State of M	Marylan		artment o			Mental Hy	9	0.07	01307
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/Med		4a. Facility Name (If not institution, give		ər)		4b. City, To	wn, or Loca	ation of Dea			County of Death	
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4 1		Usual Residence of Decedent										
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permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from Sta	10	Place of Dispo	natory or othe	r place)	1 / 5	Date / 2007		cation - City or T	
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DIVIDIO TO VICE THE PROPERTY TO THE HOSPITAL OF Attending Physician: The law within 24 hours effer death.  To the Funarel Director: After this certificate has a completely filled in by the funeral director, page 2.	M	29b. Signature and title of certifier	12	1			icense nun	nber		29d. Dat	e signed (Month,	Day, Year)
		) Would				D2	25079			ll	2/07	
1151		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type,	Print)	-					
		Don H. Yablonowi	tz, MD 7	7404 E	xecuti	ve Pla	ce, #	502,	Lanham, 1	Mary]	Land 207	06-6238
The State of	State	31. Date filed (Month, Day, Year)	32. Regi	istrar's Signa	bours.	•						

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	Division		1. Decedent's Name	(First, Middle, La	st)						2. Date of De	ath			Time of Death
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	Examin	er		*	e street and number)		. 1 0	4b. City, Tow					. County of E		
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	ams a	Funerai	11. Marital Status		12. Was Decedent Armed Forces?		.S. 13.	Was Decedent If Yes, specify (			cify Yes or No	)-	14. Race - A	American Ind	tian,
36	J within 72 hours after death with the Marylan jiene. r than "natural", or itams 23e or 28e-f show the Medical Examinat mat be notified at	by Fu	1 ☐ Never Marrie 3 ☐ Widowed		1 MYes 2 ☐ If Yes, Give	No		1 ☐ Yes 2 🗓			ilozii, oto./		Specify:	White	3
0	hour		3 🗆 Widowed	15. Decedent's Ed	Year or Dates:	WWI		dent's Usual Oc	cupation			16b K	(ind of Busine		
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Maryland 21215-0036	ed la p	Be	17. Father's Name (	First, Middle, Last, Edwar		11-0+					(First, Middle		,		
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re,	of Health of Health fitem 27 r other tr		20a. Method of Disp	osition		20b. F		sition (Name o matory or other			ate		ocation - City		
E	Z :: Pa			☐Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State  y)			Cemete		1/4/	07	Oak	land,	MD	
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Fur	neral Service Licer	See			2. Name and Ad		1		. Se	cond S		
_	90 E 8 9		130	Severy Lla	lay			tewart					MD 2	21550	
			snock, or near	t failure. List only	plications that caused one cause on each li	the deatine.	h. Do not ent	er the mode of	dying, such a	s cardiac or	respiratory a	rrest,		Interv	oximate val Between et and Death
	Physician /Medical		Immediate Cause (I disease or condition resulting in death)	rinai 1	a. Gord 51	uge	Co	inchion	you	after	1			on	2 year
	Examiner			ſ	Due to (or as	a conseq	uence of):		0						,
		Jer	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	nditions, mediate	b. Due to (or as	a conseq	uence of):				-				
	ocuted nd transii	Examiner	that initiated events		c										
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68760,	ficate be executed physician and is the burial-transit	edicai			d										
_			IF FEMALE: 23b. Was decedent	oregnant	23c. If yes, outcome	of pregna	ancy						23d. Date of	dolives	
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orc	w requir been si should	eted	CVP	NOW C	Kerina	ian	ne				10	Yes 2	□No 3□	] Probably	4 Unknown
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Ta		e Co	25. Was case referr	red to medical					22 5		1 ☐ Yes	2 X No	1 0		lo
Š	nysician: nis certifica director,	0 8	examiner?		Hospital: 1 ☐ Inpatio	ent 2 🗆	ER/Outpatier	it 3□ DOA			Check on c		6 DOther /	Engo(fu)	
Division of Vital Records,	Attending Physician: r death. sctor: After this certification the funeral director.	n: T	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	iry	28b. Time of Injury		njury at Work?		3d. Describe			specity)	
Siol	ttendir death. ctor: Al y the fu	catic	2 Accident	investigation	1	, ,	,,		Yes 2	]No					
Σ̈́	i or Attendater deatl Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Inj building, et			eet, factory, offi	се	28	Bf. Location (: City or Tox	Street an wn, State	nd Number or e)	r Rural Route	e Number,
Ц	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier	1 Certifying Ph	ysician: To the best	of my kno	wledge death	a occurred at the	o timo, data a	and place, or	ad due to the	201122(2)	\ and		
	e Fur	edicai	(Check only one)	2 Medical Exar	niner: On the basis o and manner st	t examına	tion and/or in	vestigation, in n	ny opinion, de	ath occurred	d at the time,	date and	d place, and	r as stated. due to the ca	ause(s)
	To the within 2. To the I complete	Me	29b. Signature and		,			29c. Lic	ense number			29d. Da	te signed (M	onth, Day, Y	'ear)
•	10		m	moch	elu			Do	0553	325		Jan	104.	200	7
	+ I VA		1	1 () .	completed cause of c	leath (Item		Print)				. ^	<u> </u>	(0.0	
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	Sta Registr				2007	and and	A 1	anadh.							

DHMH 17 Rev 1/2001

Coddington, Harry C.

		-	For State Registrar	Sta	ate of	Maryland		artmen tificate			and Me		giene Reg. Nd	711117		309
	Physicia	,,	1. Decedent's Name (First, Middl								1	2. Date of Dea		y 2007 Yeer	3. Time	
	/Medic	al	Norma Lorraine  4a. Facility Name (If not institution			narl		4h City	Town or	Location of	of Death	JANUAI		. County of Deatl	6:30	P "
	Examin	er	St. Mary s Hos		and nume	veri)		Leon			Dean			t. Mary'		
	Funeral		5. Social Security Number	6. Sex		Age (In yrs. I	ast birthday)	If Under Months	1 Year	If Under	24 Hrs. 8	8. Date of Bird (Month, Da			hplace (State untry)	or Foreign
- 8	Director		578-46-2983	1 □ M 2	2 <b>X</b> F	80	Yrs.	WOITIIS	Days	110013	1	0/31/1	926		ingtor	
	pu ≱		Usual Residence of Decedent  10a. State 10b. County			10c. City	, Town or Lo	cation							10d. Inside	City Limits
	Manyli f sho	Į.	Maryland St.	Mary's		Leon	ardtow	m							1 ☐ Ye	s 21 No
	r 28a	rec	10e. Street and Number	1427 0				10f. Zip	Code				10g. Ci	tizen of What Co	untry?	
	th with	Funerai Director	21510 Our Driv	a Way				206						ited Sta		
	r dea	uner	11. Marital Status	A	med Forc	ent Ever in U. es?	S. 13.	Was Deced If Yes, spec	lent of Hi ify Cuba	ispanic Ori n, Mexican	gin? (Spec n, Puerto R	ify Yes or No lican, etc.)	-	14. Race - Ame Black, White		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🕅 Divorced	ned 1	☐Yes 2 Yes, Give 'ear or Dat	:Xi∾o es:		1 🗆 Yes	2 <b>∑</b> No	Specify:				Specify: Wh	ite	
Ş	2 hour	ted t	15. Deceder	nt's Education	n	-	16a. Dece	dent's Usua	l Occupa	ation	t of workin		16b. K	(ind of Business/	Industry	
215	thin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)		ollege (1-4	for 5+)	life.	kind of wo DO NOT us	se retired	d)	t Of WORKIN					
21	ygien ygien th	Con	12	(			U.S.	Post	:a1	18 Mothe	or's Name	(First, Middle		. Govern	ment	
and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, John M. Sheaff)									. Smal				
<u> </u>	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than "natural", or Iteme 23s or 28s-f show umatic event, I's Medical Evant at must be notified at	၉	19a, Informant's Name/Relation		Print)		19b. Maili	ng Address	(Street a					or Town, State, 2	Zip Code)	
<b>≥</b>	end 2 seath ar n 27 is		John G. Copado	, Sr./	Son		42510	St.	Andr	ews (	Church	h Rd.	Leo	nardtow	n, MD	20650
Baltimore, Maryland 21215-0036	一工宣布		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	3 Demo	val from Si	20b. P	lace of Dispo emetery, crea	osition (Nar matory or c	ne of ther plac	(e)	Da	ate	20c. L	ocation - City or	Town, State	
Ĕ	Pages ment of I ant: If it	3	4 ☐ Donation 5 ☐ Other (	Specify)	-	St.								George :		
3alt	permit. Departr importu any inji		21. Signature Funeral Services	2		2	2:	2. Name ar	d Addres	ss of Facili	<sup>by</sup> Brin	sfield	Fur	neral Ho	me, P.	A.
	40 E 6 G		Edward N. Br 23a. Part1. Enter the disease, c shock, or heart failure. Lis	insfie	Id, J	r. MO0	052   22 n. Do not en	ter the mod	e of dyin	WOOD g, such as	cardiac or	Leon	.ard1 rrest,	cown, Ma	Approxim	nate
			shock, or heart failure. Lis Immediate Cause (Final	t only one ca	use on ea	ch line.	1	ก	,	/					Onset an	
	Physician /Medical		disease or condition resulting in death)	a	Due to (o	r as a conseq	uence of)	12	2	. U A	5.				PIC.	100
	Examiner		Conventially list conditions	b			U									
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	Dua to (c	r as a conseq	uance of):									
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	с.	Due to (o	r as a conseq	uence of):	_								
760,	ate be executed hysicien and the burial-transit	calE		4			,									
~	ificate g phys			0.												
Copado . Box 68	h cert ending	M/m	IF FEMALE: 23b. Was decedent pregnant			ome of pregna		⊒Ectopic p	regnancy	,				23d. Date of de	-	Year
Co.	e deat he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4		int at time of d		Other (s						Month	Day	Year
ща <b>Р.О</b>	The law requires that the death certifica ste has been signed by the attending ph bage 2 should be detached for use as th	Phy	9 Unknown Part II. Other significant condit	ions contribu	uting to dea	ath but not res	ulting in the u	ınderiving (	ause div	en in Part I		23e. Did	tobacco	use contribute to	the cause of	of death?
Norma	signe d be c	d by	Pag	~		. G			<b>.</b>			1 🗆	Yes 2	2 No 3 P	robably 4	□Unknown
	requir been s should	Completed										24a. Was		24b. Were a	utopsy findin	gs available
Name:	The law cete has b page 2 s	duc								-		auto perfe 1 ☐ Yes	?be/mic	prior to death?	completion o	it cause of
ital N.	ician: Th certificete rector, pag	BeC	25. Was case referred to medic	al						26. Place	e of Death	(Check only	1		20,10	
	Physician: this certific ral director.	10 B	examiner? 1 ☐ Yes 2 ☐ Ño	Hospi	ital: 1 🌂 n	patient 2	ER/Outpatie		_	4 🗆 10				6 ☐Other (Spe	icify)	
0			27. Manner of Death 1 ☑Natural 5 ☐ Pend	iii igi	8a. Date o (Month	f Injury n, <i>Day Year)</i>	28b. Time of Injury		28c. Injur Wor			28d. Describe	how inj	ury occurred		
Division of	2 2 2 2	Cati	3 Suicide 6 Could	tigation t not be	Se Place	of Injury - At h	ome farm si	M treet factor		Yes 2		28f. Location	Street a	and Number or R	ural Route N	lumber,
Div	ofter deatl Oirector:	Certification:	4 Homicide deter	mined 2	buildin	g, etc. (Specil	<b>(y</b> )		,,			City or To	wn, Sta	te)		
_	To the Hospitel or Atta within 24 hours efter de To the Funerel Directo completely filled in by th	Medical C	29a. Certifier 1 Certify (Check only ane)	I Examiner:	n: To the On the ba and mann	sis of examina	owledge, dea ation and/or in	th occurred	at the tir n, in my o	me, date ar opinion, dea	nd place, a ath occurre	and due to the	cause( date ar	s) and manner and place, and du	s stated. s to the caus	.e(s)
	To the within 2 To the comple	Me	29b. Signature and title of certif	er	/			29	-	se number				ate signed (Mon.	-	
			· VU	M	10/1	ma			1) (	428	85			1-8-	07	,
			30. Name and address of perso	n who comple	eted cause	e of death (Iter	п 23а) (Туре	, Print)								
	C+	ate	DR. William 31. Date filed (Mogth, Day, Yea		PO 32. Re	BOX 175 egistrar's Signa	3 Leo	nardt	own,	MD 2	0650					
	Regist		JAN 1 0 2007	Been	2	1 La	ME									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Registrar	(First, Middle, Last)					2. Date of Death	Day	Yeer	3. Time of Death
hysicia			otte H. Ch	affee				January	2 2	2007	10:20p
/Medic	4		f not institution, give s				or Location of Death		4c. County		
Examin	er		Lutheran				dallstown			Baltir	
uneral rector		5. Social Security N 337–05–59		7. Age (lr	n yrs. last birthday 93 Yrs.	Months Days		8. Date of Birth (Month, Dey, July 5,	1913	9. Birtho Coun Mair	lece (State or Fore try) C
Now In	-	Jsuel Residence of 10a. State	10b. County		Oc. City, Town or					1	0d. Inside City Lim
a-f s	ctor	Md.	Baltin	more	Randa.	llstown		1	0g. Citizen of	What Cour	ntry?
a or 28	Dire	10e. Street and Nu	mpfield Ro	a.		10f. Zip Code 21	207		US		
regain any water 175,000.  Them 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic systit, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status	ried 2 Married	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No			Specif	ce - Americ ick, White, fy: Whi	etc. te
natura dical E	eted	(Spec	15. Decedent's Educify only highest grade	e completed)	life	cedent's Usual Docu ve kind of work done DO NOT use retin	upation a during most of wor ed)	king	16b. Kind of B	Business/In	dustry
the Me	lduic	Elementary/Seco	ondary (0-12)	College (1-4or 5+) 4yrs		Teacher				Educa	tion
is marked other than aumatic sysnt, it a Me	Be		(First, Middle, Last) L. Hess					ne (First, Middle, I SSE Bar	Maiden Suma tlett	me)	
narked o	은		Name/Relationship (Ty	ina Print)	19b. Ma	ailing Address (Stree	et and Number or Ru	ıral Route Number	r, City or Town	ı, State, Zip	o Code)
7 is m				naffee/son			view Ct.	Ellicott		4d. 2	1042
Department of regular a Important: If item 27 is any injury or other training once.		° 4 □ Donation	Cremation 3 S 5 Other (Specify)	Removal from State	Arlingto	22. Name and Add	1 Cem. 1/2 I cem. 1/2 Iress of Facili Har Columbia	TA H.MTC	zke's I	ngton amil City,	y F.H.In
35 6 8		23a. Part1. Enter shock, or he	the disease, or comport failure. List only o	lications that caused the cause on each line.	ne death. Do not	enter the mode of d		c or respiratory ari			Approximate Interval Betwee Onset and Deat
/ledical				Due to (or as a	consequence of):						/
aminer	dical Examiner	Sequentially list of any, leading to cause. Enter Und Cause (Disease of that initiated ever resulting in death	derlying or injury	b. Dee to (or as a)	consequence of):						1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200<u>7</u> **Physician** 12:00pm M January 8, Diven /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Princess Anne 12460 Pars Lane Somerset If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/23/1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1.X M 2□F 212-12-7071 86 Director Maryland Usual Residence of Decedent fited within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director Somerset Princess Anne 10g, Citizen of What Country? 10e Street and Number 10f Zin Code USA 12460 Pars Lane 21853 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3. Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Plumbing Home repairs none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any injury or other traumatic event once. Be George Edward Diven Mary E. Ceis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20707 44B Street, Laurel, MD Margaret Lewis/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 01/15/2007 Salisbury, Maryland 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licenses 1/01/00295 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21853 Approximate interval Between Onset and Death mediate Cause (Final MYOCARDIAL INFARCTION Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Year Month Day ĵ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASCVD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 🗆 No 1 ☐ Yes 2 ☐ No 1 TYes certificate or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No this 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number -67 91 2007 D 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALL HIGHWAY, CRISFIELD, MD, 21817 Dr. VIJAY KARUMBUNATHAN 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elsen & Speck Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Division or Vital Records, P.O. Box 68760.

		1 - State of Maryland / Department of Health and length of Per FH G864 2/05/01/11	Mental Hy	/giene	7 01312
	-11	Negistral     Decedent's Name (First, Middle, Last)	2. Date of D	than G G	3. Time of Death
Physici		T-ll v	Month	Day Yea	0(1/0 M
/Medi Examir		Edward Vernon Dorsey 4a_Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl	h	4c. County of De	
	44	Peninsula legional medical Center Salisbury		Wice	mico
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) IT Under 1 Year II Under 24 Hrs. Months Days Hours Min	8. Date of B	irth 9. E	Birthplace (State or Foreign Country)
Director		218-16-2063 82 Yrs.	03/01/	2	aryland
and with		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d, Inside City Limits
Maryl f sho	ō	MD Somerset Princess Anne			1 □Yes 2 No
the 28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
3a ol		28333 Mt. Vernon Road 21853		USA	,
deatl	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or N		merican Indian,
72 hours after death with the Maryland 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		1 □ Never Married 2 Married 1 1 ☑ Yes 2 □ No 1 □ Yes 3 ☑ No Specify:	to Hican, etc.)		
Jral",	d by	3 □ Wildowed 4 □ Divorced Year or Dates: WWII		Specify:	
"nat	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired)	rking	16b. Kind of Busines	ss/Industry
filed within Hygiene. Ther than "		Elementary/Secondary (0-12) College (1-4or 5+) 12 Priest			
Hygi Hygi			ne (First, Middle	Ministry e, Maiden Surname)	У
should be ind Mental marked o	To Be	John Edward Dorsey Gladys	,	nia Smith	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru			e, Zip Code)
and 2 ealth a n 27 is		Laura Miller Dorsey/Wife 28333 Mt. Vernon Roa			
of He standard		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		or Town State, MD
Pages 1 gnent of He nort  or other north		4 Denetion E Other (Conside)	<del>~07</del> <b>3-2007</b>		- Maryland
permit. Departrillimports any Inju	1	2) Signature of Funeral service vicensee Hinman Funeral Hom.	J-Z(M)/	00113001	- nary raine
3 89 E 8 9		MO0295 11673 Somerset Ave	Prin	cess Anne.	MD 21853
		/238. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart failure. List only one cause on each line.	or respiratory	arrest,	Approximate Interval Between
Physician	4	Immediate Cause (Final disease or condition a Hypoxic Encephacopath	Ly		Onset and Death
/Medical		mmediate Cause (Final disease or condition resulting in death)  A. HYPOXIC ENCEPHACOPATH  Due to (or as a consequence of):  Respinatory Failure  b. Respinatory Failure	1		
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ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
xecut and II-trar	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
icate be executed physician and streets the burial-transit					
) ± ± o	edical	S.d			
The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the	W/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of d	delivery
d for	sician/M	in the past 12 months?  1   Ves 2   No   4   Pregnant at time of death   5   Other (specify)		Month	Day Year
t the	Phys	9 ☐ Unknown			
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w require been sig		Renal Failure	10	Yes 2⊠ No 3□	Probably 4 ☐Unknown
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The I	E		perf	formed?   death	o completion of cause of ? es 2 □ No
sician; The last certificate ha	Be C	25. Was case referred to medical examiner? 26. Place of Dea			03 2 110
- > <u>~</u> 0	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 Res	sidence 6 □Other (S <sub>i</sub>	oecity)
Ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe	how injury occurred	
tendi tor; / the fu	Certification:	2 Accident investigation M 1 Yes 2 No			
or At fiter d Direc in by	ŧ	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
pital ours a eral I		29a. Certifier 154 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place	and due to the		
24 hc 24 hc Fun etely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	rred at the time	e cause(s) and manner e, date and place, and c	as stated. lue to the cause(s)
To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
		Vaul Rothern mo 024872		1/5/0	7
		(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.  29b. Signature and title of certifier  29c. License number  22 D 24872  30. Name and address of person who corpoleted cause of death (Item 23a) (Type, Print)  Paur R F Leury 305 Terra ST Pocomoker  31. Date filed (Month, Day, Year)  32. Registrar's Signature  JAN 0 9 2007		7 - 1 - 1	
		PAUL R FLEURY 305 TENT ST POCOMOKE	e City	MO 2	1851
Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature			
Regist	rar	JAN 0 9 2007 Seem & Small.			

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		_	For State Registrar		State o	of Maryla		artment of H			Re	g. No.	007	013	13
	Physicia	en.	Decedent's Name (Fig. 1)								2. Date of Deat Month	h Day 8	Year	3. Time of	Death
	/Medic	al	4a. Facility Name (If not		inn Distl			4b. City, Town, or	Location (		lanuary		2007 ounty of Death	0130	141
	Examin	er	Atlantic		-			Berli		or o outin			cester		
	Funeral		5. Social Security Numb		6. Sex	7. Age (In yrs	s. last birthday,	ff Under 1 Year Months Days		A.A.in	B. Date of Birth		9. Birth	place (State o	r Foreign
	Director		213-36-401		1 □ M 2 <b>X</b> □ F	67	Yrs.	WOITHIS Days	Tiours	A	(Month, Day, lug. 23	, 193	9 MD		
	and *	}	Usual Residence of Dec 10a. State 10	b. County		10c. C	City, Town or L	ocation						10d. Inside Ci	ty Limits
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	ours after deeth with the Marylar raf', or iteme 23a or 28a-f show Examinar must be notified at	Funeral Director	10e. Street and Numbe	r				10f. Zip Code			1	0g. Citize	n of What Cou	untry?	
	th with	aiD	1214 Carro	11ton	Lane			2181				UŞA			
	teme	Jue	11. Marital Status		Armed F		U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori ın, Mexicar	igin? (Speci n, Puerto Ri	ify Yes or No- ican, etc.)	14.	Race - Amer Black, White		
36	rs afte	by Fi	1 Never Married 3 Widowed 4		ed 1 ☐ Yes If Yes, G Year or I	2 📉 No ive Dates:		1 ☐ Yes 2 🔀 No	Specify:	:		S	pecify: Whi	te	
8	72 hours after deeth w "naturel", or iteme 23a edicel Exantiner must t		15.	. Decedent	s Education		16a. Dece	dent's Usual Occup	ation	at of working		16b. Kind	of Business/l	ndustry	
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21	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "natural", or iteme 23a or 28a-f show event, tre Medical Examinat must be motified at	Con	12				Home	maker	10 Moth	or's Namo /	(First, Middle, I		Home		
and	be fill d oth	Be	17. Father's Name (First Frederic							le Re		vialderi St	innamo)		
<u> </u>	thould ad Me mark matic	٦ و	19a. Informant's Name				19b. Mail	ing Address (Street				; City or T	own, State, Z	ip Code)	
∑ S	alth ar 27 is 27 is		William G	. Dis	tler, Sr	•	1214	Carrollt	on La	ne, B	erlin,	Md.	21811		
ore,	of Herrican		20a. Method of Disposi		3 DRemoval from	20b	Place of Disp cemetery, cre	osition (Name of matory or other place		Da	-		tion - City or 1		
Ë	Pag ment ant: i		4 □ Donation 5 [	Other (Sp	oecify)	Ca									
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any injury or other treumatic event, tra Medical once.		21. Signature Funer	Cape Henlopen Crem. 1-09-2007 Frankford, DE  Signature Funeral Service Cressee  22. Name and Address of Facility The Burbage Funeral Home  108 William St., Berlin, Md. 21811											
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)130 68760,	Medical Examination of the prize of the priz	dicai Examiner	Immediate Cause (Fin disease or condition resulting in death)  Sequentially list condit if any, leading to immediate. Enter Underlyi Cause (Disease or init that initiated events resulting in death) Las	ions, idiate ng iry	a. Due to	(or as a cons	equence of):	ventilog	TUW	Sq	ndnn	ne		Onset and	Death
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DOB! 8 DOD! 1/ al Recor		Completed									24a. Was a autop: perfor 1 Yes	sy med?	prior to death?	topsy findings completion of c	available cause of
A. A. ⊈ ∀ital	tending Phyeician: leath. tor: After this certifice the tuneral director,	Be	25. Was case referred examiner?		Hospital:			10#	205		Check only or		700		
	Physic this c	5	1 Yes 2 No		28a, 0 at	e of Injury	ER/Outpation 28b. Time	all SU DOA	4014		ne 5 ☐ Resid 8d. Describe h			cify)	
Beverly 4018 ision of	ing Viter une	tlon		5 Pendin	g (Mo	nth, Day Year	) Infury		rk? ]Yes 2.∐	]No					
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Distler 213-36- Di	To the Hospital or Att within 24 hours after de To the Funerel Direct completely filled in by t	Medical C	29a. Certifier (Check only one) 2[	Certifyin Medical	ng Physician: To t Examiner: On the and ma	he best of my l basis of exam inner stated.	knowledge, dea ination and/or	ath occurred at the ti	me, date a opinion, de	and place, a			1 -1		s)
VIV	To the within To the comp	×	29b. Signature and titl	e of certifie	Pin	MeD	4	29c. Licens	45	85		29d. Date	Signed (Mont)	h, Day, Year)	
	BA 5		30 Namerand address	lei	rela 9	73)	1/091	Hilley	D	Ber	lin A	M	2181	1	
	Sta Regist	ate rar	31. Date filed (Molph),		9 2007	Hopstrar's Si	gnäture ,	Sports							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:03 PM 1 - 1 - 2007Gloria V Dodson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Forestville Prince George's 2104 Weber Drive 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2□XF Yrs. Washington Dc 58 Director 578-64-8987 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haatth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Forestville Md Prince George's 10e. Street and Number 10g. Citizen of What Country? USA 2104 Weber Drive 20747 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedenf of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 Yas 20No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Special Education Teacher PG Co Public School 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Baker Rainey Belle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Weber Dr Forestville Md 20747 Tyrone P Dodson Sr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/9/07 Cheltenham Md Cheltenham Cemetery 22. Name and Address of Facility Taylor Funeral Home 21. Signature of Funeral Service Licensee. 1722 North Capital Street NW 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Coronary Artery Disease Examiner Due to (or es e consequence of): Physiclan/Medical Examiner Chronic Renal Failure nding physician and use as the burial-transit The law requiras that the daath cardificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Hypertension Due to (or as a consequence of): been signed by the attending should be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown Anemia þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed s certificate has t director, page 2 s 1 ☐ Yes 20000 1 ☐ Yes 2 XNo or Attending Physician: After this certific a funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🗖 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Tes 2 No investigetion neral Director: A ritled in by tha fo 2 Accident 6 Could nof be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Vithin 2

Registrar

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

29b. Signature and title of certified

and manner steted.

Suzan Abdo, MD 5005 Signal Bell Lane #202 Clarksville, Md 21029 31. Date filed (Month, Day, Year)
JAN 0 5 2007 32. Registrar's Signatur

29c. License number

29d. Date signed (Month, Day, Year) January 4, 2007

			For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Ma	ryland / De		nt of H	lealth an	nd Mei	•	giene	007	0   3   5	
	Physicia /Medic Examin	al -	Peter David Warrer  4a. Facility Name (If not institution, give s  Glady Spellman Hos	treet and number)	l Nursing	Chev	er1y		Death	Month Jan.	2 , Day 4c. P1	2007 County of Dea cince G	11:46 A <sup>M</sup> th eorges	
·	Funeral Director	=3.	5. Social Security Number 219-21-4634 6. Sex 11  Usual Residence of Decedent	7. Age [M 2 F 42		Months s.	Days	Hours Hours	Hrs. 8.	Date of Bi (Month, Di ept.	th y, Year)	9. Bir O Was	thplace (State or Foreign puntry) hington, DC	
	the Maryland 28a-f show notified at	rector	10a. State 10b. County Prince Geo	orges	10c. City, Town of Capitol	Height	S p Code				10g. Citi	zen of What C	10d. Inside City Limits 1  Yes 2 XNo	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene 18 marked other then "natural", or iteme 23a or 28a-f show eumstic event, the Medical Examinar must be notified at	by Funeral Director	305 69th Street  11. Marital Status  1 🗷 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	iver in U.S.	2 07  13. Was Dece If Yes, spi  1 □ Yes	edent of H	ispanic Origin n, Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or Ne can, etc.)		S. A.  14. Race - Ame Black, Whi	te, etc.	
CA	od within 72 hou giene. er then "natura . It e Medical E	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		+) (C	ecedent's Usi Give kind of w fe. DO NOT rity G	ork done d use retired	during most of			Pri		/Industry adustry	
Maryland	should be fife nd Mental Hy marked othe	To Be (	17. Father's Name (First, Middle, Last) Robert Davis 19a. Informant's Name/Relationship (Ty		19b. N	Mailing Addres	ss (Street	18. Mother's  Marie  and Number of	A1ma	a Harv	in	Sumame) r Town, State,	Zip Code)	
e,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any injury or other treumatic anges.		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1											
i jegovi Roje											ple			
	thet the death certificate be executed  Way  By the attending physician and detached for use as the burial-transit	dicai Examiner	disease or condition resulting in death)  Sequentially list courting if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a Due to (or a) Due to (or	Pulmonar a consequence of) ongestiv a consequence of) yopathy a consequence of) nsive Ca	e Hear	t Fa		ease					
P.O. Box 6	the death certifi y the attending   ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 Ectopic   5 Other (s		1				23d. Date of de Month	livery Day Year	
	The law requires ete has been sign page 2 should be	Completed by Pt	Part II. Other significant conditions cor	stributing to death bu	t not resulting in the	ne underlying	cause giv	en in Part I.		1 🗆 24a. Was	Yes 2	X No 3 □ P	or the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of second second second second second second second second second second second second second second second second second second sec	
ion of Vital	ling Ph	25. Was case referred to medical examiner?  1								5 ☐ Res	idence			
Division	To the Hospitel or Attending Phymin 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	i Certification:	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due								wn, State	)	ural Route Number,	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medicai	29a. Certifier (Check only one)  1 ★ Certifying Phy 2 ★ Medical Exami  29b. Signature and title of certifier	ner: On the best of and manner sta	examination and/	or investigation	n, in my o	ne, date and ppinion, death	occurred	at the time	date and	and manner a place, and du	e to the cause(s)	
1/R	(7) Sta	te	30. Name a address of person who concept the comberbate of the com	h, 3001 H			Chev	erly,	MD 2	0785	-//	90,		

		For	State of Ma	ıryland / [	-			Mental Hy	giene		
		State Registrar	4)		Certific	ate of L	Jeath	2. Date of De	Reg. No. 2	007	3. Time of Death
Physici	an	1. Decedent's Name (First, Middle, L	_	ama	cka			_Month	Day	Year 2007	1422 PM
/Medic		4a. Facility Name (If not institution, gi		MOI 10C		City, Town, or	Location of Death	Jan		nty of Death	17231
Examin	ler	Shady Grove Adver		tal	Ro	ckvill	Le		Mon	tgomer	У
Funeral		,	Sex 7. Age	(In yrs. last bi	Mon	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th ay Year	9. Birthp	place (State or Foreign
Director		211-38-1243	IT M ZLIF	57	Yrs.			Jan. I	5, 194	9 Penn	sylvania
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits
Mary a-f sh fied a	ţ	Maryland Montgo	nery	Gaithe	rsburg	5					1 MYes 2 □ No
th the or 28% e noti	)irec	10e. Street and Number			101	. Zip Code			10g. Citizen o		•
23a cust b	la l	32 Napa Valley Ro				20878				d Stat	
d <b>Z   Z   3-UU30</b> filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	/ Funeral Director	11. Marital Status  1 ☐ Never Married	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give			ecedent of Hi specify Cuba es 2 <b>K</b> No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	В	Race - Americ Black, White, ecify: T.1	etc.
hours tural";	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a	. Decedent's	Hsual Occup	ation			f Business/In	hite
in 72 in 72 in 74	Completed	(Specify only highest g	rade completed)		(Give kind o	of work done of OT use retired	during most of wor	king		Dudinocom	,
d with giene.	E	Elementary/Secondary (0-12)	College (1-4or 5 5+	Ps	ychotl	erapis	st		Medi	cal	
d be file ental Hy ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last Leo M. Damaska	st)				18. Mother's Nan Deborah		, Maiden Surn	iame)	
DEBILLIMOYCE, INIGITYIBING ZIZID-UU3O permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's Name/Relationship Maureen Damaska/	(Type. Print) Wife				and Number or Ru 7 Road, (				
TOFE, ages 1 and of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		cewer	of Disposition	(Name of or other place				on - City or To	
Saltimo bermit. Pages Department of mportant: If i iny injury or once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Ce	metery 22. Nan	ne and Addres	200 ss of Facility De		Willia neral H		
Dep Dep any	di V	TRACY A.	triver							-	nd 20877
⊾ Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	y one cause on each lir	the death. Do		mode of dyin	g, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	м	a consequence							, society)
Examiner	L	Sequentially list conditions,									
ed isit	ine	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury									
od / bu, cate be executed physician and the buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
& fou, cate be ex ohysician the burial	dical	d									
tificat rg phy as th	Medi	15 FFWALE									
cords, P.O. Box b8/bu, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	/sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		pic pregnancy er <i>(specify)</i>	/		1	Date of delive Month	ery Day Year
ords, P.O. requires that the een signed by the hould be detache	/ Physi	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underly	ing cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
rdS quires n sign uld be	d by							1 🗆	Yes 2 □ No	o 3□ Prol	bably 4 Unknown
VITAI HECOTGS, sician: The law requires t certificate has been signe irector, page 2 should be o	Completed					·			opsy ormed?	prior to co death?	opsy findings available impletion of cause of
_ F # 6	a)	25. Was case referred to medical	1			325	26. Place of Dea	1  Yes ath (Check only	2/No No one)	1 ☐ Yes	2 □ No
Or VITA Physician: rthis certifical all director,	To B	examiner? 1 ☐ Yes No	Hospital: 1 Inpatie	ent 2□ER/O	utpatient 3[	□ DOA Oth	er: 4□ Nursing F	lome 5□Res	idence 6 🗆	Other (Speci	fy)
ION OF nding Phy th. : After this e fune ald		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju (Month, Da		Time of Injury	28c. Injur Wor 1 🗆	yat k? Yes 2 ∐ No	28d. Describe	how injury oc	curred	
LIVISION I or Attending a er death. Director: After d n by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, f c. (Specify)	arm, street, fa	actory, office		28f. Location City or To	(Street and Nu own, State)	ımber or Rur	al Route Number,
LIVISION To the Hospital or Attending within 24 hours a fer death. To the Funeral Director: After completely filled in by the fune	Medical C		Physician: To the best aminer: On the basis o and manner st	f examination a							
To the within To the	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date sig		
14		* Lauxe	1			Do	06450	2-	Jan	2,2	2007
,		30. Name and address of Person wh	o completed cause of d	leath (Item 23a)	(Type, Print)		D 3 4 =	0.04.	11 - 1 -	10 3	
		Brian Carpen  31. Date filed (Month, Day, Year)	-€V 4401	MCM (	al Co	nter	Brive,	KOCKVI	HE, M	11 30	850
St Regist	ate rar		2007	es the	BORN	8	Drive,				

			1 - For State Registrar	State of Maryla			of Health and of Death		giene neg. No. 007	01317			
	Physici		1. Decedent's Name (First, Middle, Las Mary Jane Do	•				2. Date of Dea Month	Day Year	3. Time of Death			
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, To	wn, or Location of Dea	10 00 100	4c. County of Dea				
À.			Washington Cou	nty Hospital			Hagerstown		Washir	ngton			
	Funeral		5. Social Security Number 6. So	M 21XE	. last birthday)		Year If Under 24 Hr Pays Hours Min	n. (Month, Day	y, Year) 9. Bir	thplace (State or Foreign ountry)			
	Director		217-14-4380 Usual Residence of Decedent	8	2 Yrs.			May 15	, 1924 N	Maryland			
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits			
	Man,	tor	Maryland Washing	ton	Hage	erstown				1 ☐ Yes 2 💢 No			
	or 28	Director	10e. Street and Number		nage	10f. Zip Co			10g. Citizen of What Co	ountry?			
	23a		15145 Bloyers	Ave.			21740		US	SA			
	tomes des	Funerai	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent If Yes, specify	t ol Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whit				
36	rs afte	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 <b>)</b>	No Specify:		Specify:				
9	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow he Madical Examicar coast be notified at		15. Decedent's Ed		16a. Dece	dent's Usual C	Occupation		16b. Kind of Business	White Industry			
215	hin 72	Completed	(Specify only highest gra-	de completed)  College (1-4or 5+)	(Give	kind of work of DO NOT use r	done during most of w retired)	orking		,			
21	giene giene	S I	7			Hous	ewife		Hom	ie			
D	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,					
yla	ould Men Marke	မှ	Walter Smith				Mary		ine Atkins				
Mar	12 sh h and 7 to m traum		19a. Informant's Name/Relationship (7	ype, Print)					r, City or Town, State, .				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural; or iteme 23a or 28a-1 show wayl injury or other traumatic event, the Madical Examination cast the notified at ADRS.	3	Walter Dom - Son  20a. Method of Disposition	20b.	Place of Dispo cemetery, crei				11, West V				
nor	ages ont of t: if it		1/MBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Heilioval Holli State			i						
Ħ	artme orten Injur	1	21. Sign ture of F neral Service Lorin		dar Law	in Mem.	Park Jan. Tüneray H	10,2007 F	lagerstown.				
ä	Depa Depa Impo eny lo	Ų. J						-	lliamsport	21795 Maryland			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea	th. Do not ent	er the mode of	f dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Acute	Re	nal	Failu	11		Onset and Death			
	/Medical		resulting in death)	Due to (or as a conse		, - ,							
	Examiner		Sequentially list conditions,	b. Hyrot									
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consen									
	xecut and al-trar	хап	that initiated events resulting in death) Last	c. Due to (or as a consec	guence of);								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	alE											
9	ifficate g phy as the	Physician/Medical		u						-			
Вох	that the death certific ed by the attending p detached for use as	N/	230. Was decedent program	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	ancy	Ectopic pregn			23d. Date of de	livery			
B	ed for	sicia	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time of o		Other (specif			Month	Day Year			
P.O.	d by the	Phy	9 Unknown				V2.51						
	ires the signer	by	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying caus	e given in Part I.		bacco use contribute to				
Ö	w requires to been signer should be a	Completed						-		obably 4 Hmknown			
Bec	hes ge 2 s	Idm						24a. Was a autops perform	y prior to	itopsy findings available completion of cause of			
ā	iclen: Th certificate rector, pag		25. Was case referred to medical					1 ☐ Yes	2 No 1 Yes	2□ No			
5	Physicien: r this certifica ral director, I	o Be	examiner?	Hospital: 1 Inpatient 2	] ER/Outpatier	nt 3□ DOA	04	eath Check only on	ence 6 ⊡Other (Spe	-6.1			
0	g Phys er this eral di	Ë	27. Manner of Death	28a. Date of Injury	28b. Time of		Injury at Work?	1	ow injury occurred	cny)			
ion	Attending I ir death. ector: After by the funer	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ No						
Division of Vital Records,	after deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, of	fice	28f. Location (St City or Town	reet and Number or Run, State)	ıral Route Number,			
	itel or rai Dir iled in												
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the vestigation, in a	ne time, date and place my opinion, death occ	e, and due to the caured at the time, d	ause(s) and ma <i>n</i> ner as ate and place, and due	stated. to the cause(s)			
	To the within 2 To the complex	Me	29b. Signature and title of certifier				cense number	2	9d. Date signed (Mont	h, Day, Year)			
ر(	18		I fail m	huh		00	160396		01/05/0	,7			
	1		30. Name and address of person who co		m 23a) (Type,	Print)	26 OP	al ct		0.44.00			
	,			JA-SHED			Hair	stown	MD 3	1740			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	di. On	cels)	ď						

Specify. White 16b. Kind of Business/Industry Livestock Dealer 18. Mother's Name (First, Middle, Maiden Surname) Robertta Fries 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21783 Smithsburg, Maryland 20c. Location - City or Town, State Rest Haven Cemetery Jan.11,2007 Hagerstown, Maryland 21795 425 S. Conococheague St. Williamsport, Maryland Approximate Interval Between Onset and Death 2-32 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Certification: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D (8019 JAN 8, 2007 -aut mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAGERSTOWN MID 21740 MILLST DATTA ~ 0 340 31. Date filed (Month, Day, Year) 32. Registrar's Signature DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

537 AM

Birthplace (State or Foreign Country)

USA

10d. Inside City Limits

1 ☐ Yes 2 X No

State Registrar

John Humbert Dixon State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1 Decedent's Name (First, Middle, Last) 3. Time of Death Medical Examiner 1500 hrs January 4, 2007 John Humbert Dixon, Sr. 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Scotland St. Mary's Point Lookout State Park 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Months Days Hours Director Country Georgia 02/27/1952 256-84-7885 1 X M 2 54 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 23a or 28a-f show notified at once. Lexington Park Yes 2 X No Maryland St. Mary's death with the Maryland Director 10e. Street and Number 10g Citizen of What Country 10f. Zip Code 21328 Williams Drive 20653 United States or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married X Yes after Yes, Give Year Widowed Yes 2 X No specify: Divorced Specify: White <u>გ</u> 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed ges I and 2 should be filed within 72 l.
t of Health and Mental Hygiene
If item 27 is marked other these Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than atic event, the Medical 21215-0036 Avionics Technician Defense 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be traumatic event, George Matthew Dixon Virginia Doughty 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne E. Dixon/ Wife 21328 Williams Drive, Lexington Park, MD 20653 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State Baltimore, permit Pages I Department of H Important: If i Burial 2 X Cremation 3 Removal from State crematory or other place) or other nsfield-Echols Cre. 01/06/2007 |Charlotte Hall, MD Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01205 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure List only one cause on each line. Between Onset and /Medical Death a Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of); Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED certificate be Division of Vital Records, P.O. Box 68760, attending phys for use as the bi IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the detached Part II. Other significant conditions s been signed by should be detach contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive Arteriosclerotic Cardiovascular Disease Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 2 No ✓ Yes ospital or Attending Physician: hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene ٩ 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work' 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Subject drowned in bay FOUND Natural Pending Yes 2 V No the f Director: Jan 4, 2007 1430 hrs 2 🗸 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Point Lookout State Park, Scotland, MD determined (Specify) Bay Funera Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E January 5, 2007 ame and address of person who complet e of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Brew & Ap

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Manyland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 2007 Jan 11:15 Martha J. Dorsev /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 901 E. Ridgeville Blvd. Carroll Mt. Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√√ F Sept 10, 1919 Director 215-78-5776 87 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Mt. Airv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 E. Rideville Blvd 21771 United States Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2KXNo Specify: Specify: Black à 3√XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na eny injury or other traumatic event, if a Media once. Elementary/Secondary (0-12) College (1-4or 5+) House Wife her hane 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Anderson Laura Potts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Browner (grandson) 704 Veronica Dr. Pittsburgh, PA 15235 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 1/9/2007 Taylorsville, MD Fairview Cen. 21. Signature of Funeral Service I 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. Comthell 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a HYPERTOUSIVE CARDIOVASCULAR Immediate Cause (Final disease or condition resulting in death) DISEASE **Physician** /Medical Due to (or as a consequence of) Examiner CERTIFICATION REPROVED BY MEDICAL EVANIMER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, nding physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hip Fracture 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After T DINATURAL 5 Pending Subject fell 1 ☐ Yes 2 No investigation 12/03/2006 Unknown M 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Church Location (Street and Nymber or Rural Route Number, City or Town, State) Mt. Airy, MD 4 Homicide 807 E. Ridgeville Boulevard 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number () 26499 29d. Date signed (Month, Day, Year) 29b. Signature and tills 1-4-07 and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, MD 4 Culwell Dr. PO Box 210 Mt. Airy, MD 21771 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 4 2007 Registrar

07-00268

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Paul Dickerson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examiner Michael Pau1 Dickerson 1915 hrs January 9, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 9719 Narragansett Parkway College Park Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Director Hours 220-70-4954 49 Apr. 19, Country Missouri 1X M 2 1957 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 28a-f show 1 X Yes 2 No MD Prince George's College Park with the Maryland Director s 23a or 28a-f e notified at o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 9719 Narragansett Parkway 20740 USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 1 X Never Married 2 Married Yes 2 X No Divorced Yes, Give Yea marked other than "natural", c event, the Medical Examiner Yes 2X No specify: Specify: White ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 and Mental Hygiene Baltimore, MD 21215-0036 Plumber 1 Plumbing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John Wilson Dickerson Elizabeth Ann Hall 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 should Department of Health and Mulmportant: If item 27 is mainjury or other traumatic e Charles A. Dickerson/brother 14501 Becker Rd. Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Chesapeake Crematory 01/13/07 Beltsville, MD Donation 5 Other Specify: Signature of Funeral Service Licen-2 Name and Address of Facility Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Complications of chronic drug and alcohol use Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and tran d Physician/Medical attending physician or use as the burial -X UNPENDED #23a,27,perME Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed s been s 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? Yes 2 No ✓ Yes No 25. Was case referred to medical Hospital or Attending Physician: 26.Place of Death (Check only one) Be Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending r death Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 24 hours a Fuueral I determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 To the 1 one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 0 and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 10, 2007 30 Name and address of person who complete cause of death (Item 23a) 0 00 Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 strar's Signature 31. Date filed (Month) Year) 6 State 2007 BY AR

Registra

07-00274 Towanda Geann	ette	Please Type or Prin	nt in Black Indelil ryland / Departme					•	07 0100
Physicia		For State legistrar 1 Decedent's Name (First, Middle, Last)	Certifica			u wentar n	_	eg No.	3. Time of Death
Medical Exami	111/4	TOWANDA J. EAST	MAN				Month January 9	Day Year	2230 hrs
-de-		4a. Facility Name (if not institution, give street ar 4614 Bishop Carroll Drive	nd number)	1	4b. City, Town, or Upper Marl	Location of Death		4c. County of Prince Ge	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday)	If Under 1 Yea	If Under 24Hrs.	8. Date of Bir	th(MM/DD/YYYY)	Birthplace (State or
Director		125-64-0405 1_M 2	X <sub>F</sub> 37	Yrs	Months Day	s Hours Min.	MAY 6	1969	Foreign NEW YORK Country)
auò	-	Usual Residence of Decedent 10a State 10b. County	10c. City, Town o	or Locati	on				10d Inside City Limits
* .	٦	MD PRINCE GEORG	E'S UPPER	MAI	RLBORO				1 X Yes 2 No
Baltimore, MD 21215-0036  Barnit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4614 BISHOP CARROLL D	RIVE		10f. Zip Code 20772		1+	0g Citizen of Wha	,
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e, MD and 2 sho lealth and item 27 is traumati	1	GLORIA BLACKMAN/MOTHE: 20a Method of Disposition	20b. Place of	f Dispos	ition (Name of ce		Date	YN, NEW Y	ORK 11221 ity or Town, State
more		1 X Burial 2 Cremation 3 Remove	var irotii otate	-	nerplace) DET CEME	TERY 1/1.	5/2007	TARBORO	NC
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	Σ	29b. Signature and title of certifier			29c. Licens O.C.			29d. Date signed January 10,	(Month, Day, Year)

31. Date filed (Month, Day Year JAN 16 2007 Registrar DHMH 17 Rev 1/2001 OCME 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

January 10, 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		rtificate of	Death		R	teg No	
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		4a. Facility Name (if not institution,	-	4	-	Location of Deal	th	4c County c	
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Funeral			Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Yea		_		9 Birthplace (State or
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Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tr		21 Signature of Funeral Service Li		22. Na	ame and Addres	of Facility Joi	NT. Rh		al Home LLC
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Division of Vital tal or Attending Physician: 15 after death al Director: After this certiled in by the funeral director	0	examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nursi	ng Home 5	Residence 6	Other: Scene
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riSi r Att ter de irect n by	ica	2 Accident Investign 3 Suicide 6 Could re	28e Place of Injury At he		, factory, office b	ouilding, etc.	28f. Location (S	Street and Number	r or Rural Route Number, City
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Hosp 4 hou Funer		20a Cartifar	sician: To the best of my knowled		ed at the time de	ate and place are	1		
Division of Vital Records, P.O. Box 6 within 24 the Hospital or Attending Physician: The law requires that the death center 24 thous after death To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only	ner:On the basis of examination a	nd/or investigation	on, in my opinion	, death occurred	at the time, date	and place, and du	e to the cause(s)
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W OIL		30. Name and address of person w	·		Dali:	MD 24204			
Service			Medical Examiner 111		., paitimore, i	IVID 27207			
S Regis	tate trar	JAN 0 5 2007 (Manth Day Year)	32. Registrar's Signatu	The state of the s					
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year JAMES PAUL FORD JAN. 2007 12:44A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FT. WASHINGTON HOSPITAL PRINCE GEORGES FT. WASHINGTON 8. Date of Birth (Month, Day, Ye AUG. 13, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min, **Funeral**  Birthplace (State or Foreign Country) Months Year) 1**X** M 2□ F Director 84 Yrs. 495-18-9604 1922 ILLINOIS Usual Residence of Decedent death with the Maryland 10a. State 10b Count 10c. City, Town or Location show 10d. Inside City Limits Items 23a or 28a-f shov MARYLAND PRINCE GEORGES FT. WASHINGTON Director 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 SWAN CREEK ROAD 20744 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1X Yes 2 No If Yes, Give Year or Dates: WWII Baltimore, Maryland 21215-0036 ö Completed by 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 'natural' the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 BUILDER of Health and Mental Hygie fitem 27 Ia marked other r other traumatic event, I CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HURBERT ZELL FORD ပ BERNICE E. HAMMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PURA C. FORD WIFE 1100 SWAN CREEK ROAD FT. WASHINGTON, MD 20744 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. BREVARD MEMORIAL 1 4 ☐ Donation 5 ☐ Other (Specify) JAN.6,2007 COCOA, FL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON STREET ALEXANDRIA, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscle notic **Physician** Candio Vasclar Dislane 4 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No the 9 Unknown 9 Unknown à this certificate has been signed I al director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? 1 Yes 2K No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 XER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Certification: 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After s after dea. 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Xo the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8id 1045365 01-02-20-7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Sidarous, M.D. 1170/ livingston nd HIV fort WAS lington MB 20744 31. Date filed (Month, Day, Year)

JAN 0 4 2007 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 3, Year JANUARY 3, 2007 **Physician** PHYLLIS 11:50 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Carroll Hospital Center
al Security Number 6. Sex 7. Age (In yrs. last birthday) Carrell If under est militas tack 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 217 F Days Hours Director 187-24-0029 Usual Residence of Decedent 76 <del>10-30-1930</del> PA with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits MD Directo Carroll Westminster 1 ☐ Yes 2 🛱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1028 Cherrytown Rd. death Completed by Funeral 21158

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Itam 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 Widowed 4 □ Divorced Specify: Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Switchboard Operator Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Clarence Markle Beatrice Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lonni Flickinger permit. Pages 1 and Department of Health Important: If itam 27 any Injury or other tr 1028 Cherrytown Rd. Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 1/4/07 Hampstead, MD 21. Signature Funeral Service License Littlestown, PA 17340 Little's Funeral Home 34 Maple Áve. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL **Physician** INFARCTION /Medical Examiner ARDIOMYO Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Examiner physician and s the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and DISEASE Due to (or as a consequence of): Records, P.O. Box 68760 Be Completed by Physician/Medical ned by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No : After this certification, a funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No the th 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier 3. Heloy M.D D0017695 51 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 200 Memorial Avenue, Westerins ABDAL LAH . HELOU, MD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar 2007

Physician /Medical Examiner	۱	<ol> <li>Decedent's Name (First, Middle</li> </ol>							12	Date of Death	1		3. Time of Death
		NATH		GRAN.	AT					Month JAN.	Day 3,	Year 2007	6:20 A
_		4a. Facility Name (If not institution ARCOLA HEALTH						Location of De ER SPRI				ty of Death TGOME	RY
Funeral Director		5. Social Security Number 101–01–3629	6. Sex 1 (X) M 2 □ F	7. Age (In y	rs. last birthday) 9 Yrs.	If Under Months		If Under 24 H	lin.	Date of Birth (Month, Day, EPT 9,	Year) 1917	9. Birthp Cour NEV	place (State or Foreightry) V YORK
then *naturel; or iteme 23a or 28e-f ehow ra Medicul Exantrat must be profilled at properties by Funeral Director		Usual Residence of Decedent  10a. State 10b. County  MD • MONTG0  10e. Street and Number		10c.	City, Town or Lo	SILVEI		RING		10	a. Citizen of		0d. Inside City Limit
ust be r	2	508 DEERFIE	T					20910			U.	S.A.	
Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28e-f ehow any injury or other traumatic event. If a Medical Exact set must be profitted at once.  To Be Completed by Funeral Director	2	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	ned 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 TNo		Was Deced If Yes, spec		ispanic Origin? In, Mexican, Pu Specify:	' (Specifi uerto Ric	y Yes or No- an, etc.)		ace - Americ ack, White, ify: WH	
ygiene. ner then "nature t, I'm Medicul E	Jupleter	15. Deceden (Specify only higher Elementary/Secondary (0-12)	1	(1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us SALES	rk done d se retired	during most of a	working		6b. Kind of l		dustry ODELING
Mental Hyginarkad other atic evant, I	0	17. Father's Name (First, Middle,	Last)	ANAT		SALE	SMAN		Name (F	First, Middle, M		лте)	DELING
ealth and m 27 is man ner trauma			hip <i>(Type, Print)</i>	9	508	DEERI	FIEL	D AVE.,	SII	LVER SP	RING,	MD.	20910
rtment of Hi rtent: If Ite njury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	ipecify)	State	Place of Dispo cemetery, cres CHAMBERS	natory or of CREN	ther plac MATO	RY 1-	Date -4-2(	007	0c. Location	DALE,	MD.
Impo any ir once		21. Signature of Funeral Service	anlus	MO MO	0091 Či	HAMBEI 301 CI	RS F	ss of Facility UNERAL LAND AV	HOMI E.,	E & CRE RIVERD	MATOR ALE, 1	IUM,P MD. 20	A. 0737
nysician Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. LEU	caused the de each line. KEMIA		er the mode	e of dyin	g, such as card	diac or re	espiratory arre	st,		Approximate Interval Between Onset and Death MONTHS
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se hes been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	The same of the sa	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		Ectopic pro	eonancy					ate of delive	
igned by the ettendin be detached for use by Physician/N	I yalel	in the past 12 months?  1 Yes 2 No 9 Unknown	4☐Preg 9☐ Unki	nant at time o nown	fdeath 5	Other (sp	ecify)					onth	Day Year
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Director in by the		2 Accident investig 3 Suicide 6 Could of determined	not be 28e. Plac	e of Injury - At ling, etc. (Spe	home, farm, str	eet, factory		Yes 2∐No	28f.	Location (Stre City or Town,		ber or Rura	l Route Number,
Funer Funer Gely fill	BAIR	29a. Certifier (Check only one)  1   Certifyin 2  Medical	ng Physician: To the Examiner: On the I	e best of my k basis of exami nner stated.	nowledge, death nation and/or in	occurred a	at the tim	ne, date and pla pinion, death or	ace, and	due to the cau at the time, dat	use(s) and m	nanner as si , and due to	ated. the cause(s)
To the complet		29b. Signature and title of certifie	MA	Mp	/	290		2332			d. Date signi		
State		30. N e and address of person  SURESH K.  31. Date filed (Month, Day, Year)	GUPTA, M	*	9801		IA A	VE.,SUI	TE 2	2-20, S	ILVER	SPRIM	IG, MD. 2090

**ORIGINAL** 

		1	For State Registrer	State of I	Maryland		rtment of He tificate of D			giene ( Reg. No.	07	01327
			Decedent's Name (First, Middle, L.)	.ast)					2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physicia	ın	Betty Gould						January		2007	12:15 p <sup>M</sup>
	/Medica		4a. Fecility Name (If not institution, g	ive street and numb	er)		4b. City, Town, or I	Location of Dea	th	4c. Co	ounty of Death	
	Examine	er i	Hebrew Home of			ton	Rockvill	_e		Mo	ntgome	
F	Funeral	5		. Sex 7.	Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Yeer)	Cou	place (State or Foreign intry)
	Director		172-07-7521	1 □ M 2 🖾 F	10	O Yrs.	World Days	710010	Dec. 06	, 190		nsylvania
		-	Usuel Residence of Decedent		10.0	Tour	nation					10d. Inside City Limits
	how		10a. State 10b. County			, Town or Lo						1 X Yes 2 No
	B Ma	ctol	Maryland Montgo	omery	Ro	ckvi11				10- 04-	n of Mhat Car	intri?
	or 28	Director	10e. Street and Number				10f. Zip Code			•	n of What Cou	
	23a		5801 Nicholson				20852		Specific Ven and		Lted St	
	ems erm	by Funeral	11. Marital Status	12. Was Deced	es?	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? ( n, Mexican, Pue	orto Rican, etc.)	,- 14	Black, White	
9	or It	F.	1 Never Married 2 Married	If Yes, Give		1	I ☐ Yes 2 ☒ No	Specify:		S	pecify: Wh	ite
ğ	ural',	q p	3 ☑ Widowed 4 ☐ Divorced	Year or Date	93.	16a Decer	ient's Usual Occupa	tion		16b. Kind	of Business/l	
,	"net	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	kind of work done d DO NOT use retired)	luring most of w	orking			
7	withii ene. than	mc	Elementary/Secondary (0-12)	College (1-4	or 5+)	Hor	nemaker			70	wn Home	2
Maryland 21215-0036	Hygie ther		17. Father's Name (First, Middle, La	ast)				18. Mother's N	ame (First, Middle	, Maiden S	umame)	
aŭ	d be antal rad o	m	Sam Flausbaum					Celli	e Goldst	ein		
7	shoult nd Me mark matic	ဥ	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numb	er, City or	Town, State, Z	(ip Code)
Ma	d 2 s th an th an treus		Sissy Gould /							kville	e, Mary	land 20852
á,	1 an Heal Iem 2		20a. Method of Disposition		l c	lace of Dispo	sition (Name of matory or other place		Date	20c. Loca	ation - City or	Town, State
noi	ages int of t: If it		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				oln Crema		05/2007	Bren	twood,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show Important: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other treumstic event, the Modical Examination trained at once.		21. Signature of Funeral Service to		10.		2. Name and Addres	o of Eacility				
Ba	Departiment Departiment Departiment Departiment Department Departm		DUX (1			10	40 Rockvi	lle Pik	Simple T	ribut ille.	e Marvla	and 20852
			23a. Par/1. Enter the disease, or c shock or heart failure. List or	omplications that ca	used the deat	h. Do not ent	ter the mode of dyin	g, such as card	iac or respiratory	arrest,		Approximate Interval Between
			shock or heart failure. List of								9 10	Onset and Death  2 weeks
	Physician /Medical		disease or condition resulting in death)	a. Pneum	onia or as a conseq	neuce of.						2 WEEKS
	Examiner			Due 10 (0	n as a conseq	uerice orj.						
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a conseq	uence of):						
	ted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	and al-trar	xar	that initiated events resulting in death) Last	cDue to (c	or as a conseq	uence of):						
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387	physicate t	dical		d								
9 X	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physiclan/Me	IF FEMALE:	23c. If yes, outo			75-4			2	3d. Date of del	
Вох	atten for u	slan	23b. Was decedent pregnant in the past 12 months?		nth 2∏ Feta ant at time of c		⊒Ectopic pregnancy ⊒ Other ( <i>specify)</i>	′			Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unkno								
Ф	that the de ed by the detached	/ Ph	Part II. Other significant condition	ns contributing to de	ath but not res	sulting in the u	underlying cause giv	ren in Part I.	1			o the cause of death?
Records,	uires thai signed l	Completed by	Organic Brain S						1	Yes 2 🖸	No 3∏Pi	robably 4 Unknown
OF	w requir been si should	ete							24a. Wt		24b. Were at	utopsy findings available
3ec	The law ate has b	mpl							_ aut	opsy formed?	death?	completion of cause of
<u> </u>								26 Place of I	1 ☐ Yes Death (Check onl)	2 X No	1 1 1 1 1 1 1 1	5 2 VON 19U
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		TED/Out!	ort 30 DOA Ott		g Home 5 ☐ Re		Other (Spe	ecify)
of	Phys this al dir	2	1 ☐ Yes 2X No 27. Manner of Death	28a. Date o	npatient 2	28b. Time	ant 3L DOA	463 (401311)	28d. Describ			
) U	ng l	O	1 Natural 5 Pending	g (Mont	h, Day Year)	Injury		rk? ]Yes 2□No				
Sic	tend death tor: ,	icat	2 Accident investig	not be 280 Place	of Injury - At h	nome, farm, s	treet, factory, office		28f. Location	(Street and	d Number or A	Tural Route Number,
Division	or Al ofter c Dirac in by	Certification;	4 Homicide determine	building	ng, etc. (Speci	ify)	,,		City or 7	own, State)		
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the tu	S	29a. Certifier 1 🔀 Certifyin	g Physicien: To the	best of my kn	owledge, dea	ath occurred at the ti	me, date and pl	ace, and due to the	e cause(s)	and manner a	is stated.
	Hos 24 ho Funi	ledical	(Check only 2 Medicel I	Exeminer: On the ba	asis of exa <i>m</i> in ner stated.	ation and/or i	nvestigation, in my	opinion, death o	ccurred at the tim	e, date and	place, and du	e to the cause(s)
	thin 2 the mple	Med	29b. Signature and title of certifier	,			29c. Licens	se number				nth, Day, Year)
1	F 3 F 8		A n	teen	Real	sud	D0:	36716		Jan	nuary 1	, 2007
•	1		30. Name and address of person				a Print)					
					6121 Ma	ntros	e Road, Ro	ockvi11.	e. Marvl	and 20	0852	
	· 7 A C		Andrew Kundrat  31. Date filed (Month, Day, Year)	, PI . D .	legistrar's Sign	nature	. Road , Ri	CHVELL	-,			
	S <sup>.</sup> Regis	tate trar		2007	Registrar's Sign	U. A	medi					

		ľ	1 = For State Registrar	State of Mar	yland / l		rtment of tificate of				ene g. No.	007	01329
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Catherine	Jean	Gol	.den				Date of Death Month January	Day	200 <sup>Year</sup>	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s				4b. City, Town, SALISE		of Death		4c. 0	County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 □		In yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days	r If Under	24 Hrs. 8 Min.	3. Date of Birth (Month, Day, 5/27/19)	Year) 24	9. Birth	place (State or Foreign ntry) Lorado
	yland		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Tow	m or Lo	cation						10d. Inside City Limits
	Ba-f el	ctor	Maryland Wicomic	0	Sali	sbu	-			· · · · · · · · · · · · · · · · · · ·			1 ☐XYes 2 ☐ No
	th with the 23s or 2	Funeral Director	100. Street and Number 1103 S. Schumaker	Dr., Apt.	209		10f. Zip Code 218	304		10	ig. Citiz US	en of What Cou SA	intry?
036	within 72 hours after deeth with the Maryland ene. then "natural", or Items 23e or 28esf ehow the Medical Examinar must be notified at	<u>م</u> ا	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	<ol> <li>Was Decedent Even Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give Year or Dates:</li> </ol>	er in U.S.		Vas Decedent of Yes, specify Cui ☐ Yes 2 <b>X</b> No			fy Yes or No- can, etc.)		4. Race - Amer Black, White Specify:	
21215-0036	be filed within 72 hours after deeth with the Marylan tal Hyglien. Id other than "natural", or items 23s or 28s-f show event. Its Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation completed) College (1-4or 5+)		(Give	ent's Usual Occu kind of work done OO NOT use retire	a during mos	t of working	,		d of Business/li	,
ğ	al Hygid f other	BeC	17. Father's Name (First, Middle, Last)							First, Middle, M	laiden S		•
aryland	should be nd Mental marked o	ဥ	Harold Eugene Mc  19a. Informant's Name/Relationship (Type		10	Mailin	g Address (Stree			R. But		Town State 7	n Codol
, Ma	and 2 selth and 2 selth and 27 ls		John Golden/husba	nd	1	.103	S. Schu						ry,MD 21804
altimore,	permit. Pages 1 and 2 should by Department of Heelth and Menta Important: If Item 27 is marked any Injury or other traumatic e <u>pnce</u> .		20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemete	ry, cren	sition (Name of latory or other pla Cremato		1/2/0			ation - City or T isbury,	,
Ball	Depending Depending Important In any In DOCE.		21. Signature of Funeral Service License	nemo	CFIP	<del>11</del> 5	olloway Ol Snow	Tyfer's Hill I	Mil Hon Rd., S	me Profe Salisbu	essi Cy,	onal As MD 2180	sociation 4
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the cause on each line.			or the mode of dy			N.			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence	of):							
	D N	iner	Seventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence	of):							
8760,	ficate be executed physicien and is the burial-transit	edicai Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence	of):							
P.O. Box 68	or Attending Physician: The law requires that the death certificat bited death. Diffector add Aller this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	3c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tirr 9 ☐ Unknown	Fetal death		Ectopic pregnant Other (specify)	су			23	3d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but r	not resulting i	n the ur	derlying cause g	iven in Part I.		23e. Did toba		/	the cause of death?
Division of Vital Records,	hysiclan: The law re his certificete hes be I director, page 2 sho	Completed							·	24a. Was an autopsy perform	ed?	24b. Were autoprior to codeath?	opsy findings available omptetion of cause of
Vita Vita	siclan: certifii irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2 □ ER/Oι		00 000	hac		Check only one			
ion of	Ntending Phy death. ctor: After this y the funeral d	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Dale of Injury (Month, Day Y		Time of Injury	28c. Inju	4 🗆 140	280	5 ☐ Resider  d. Describe hov			(y)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, fa	arm, stre	et, factory, office		28	f. Location (Stre City or Town,		Number or Rur	al Route Number,
	To the Hospital or within 24 hours after to the Funeral Director Completely filled in	Medical	29a. Certifier 15 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of re: On the basis of exand manner states	camination ar	e, death nd/or inv	occurred at the t estigation, in my	time, date an opinion, dea	d place, and th occurred	d due to the car at the time, da	use(s) a te and p	and manner as solace, and due to	stated. o the cause(s)
	To th To th	M	29b. Signature and tiffe of certifier				1	ise number			d. Date	signed (Month,	Day, Year)
)	0717		30. Name and ress of person who con	7 L	1 (Item 23a)	(Type I		058	410		/	- 2 -	07
			CHUGAY WAR	5 2626	26 A		1 WW 00	DC	T. SA	LISBU	4R	4 W	w. 21801
A S	Sta Registr		JAN 0 5 20	32. Pagistrar's	Signature	So	and)					1	/

Part   County   Cheek   County   Cheek   County   Cheek   County   Cheek   County   Cheek	Lela Lorraine Greene	Month Jan. 5  8. Date of Birth Month, Day, Yei 12/25/194  10g. pecify Yes or Noon Rican, etc.)	Day 2007 11:00 A M  4c. County of Death  Washington  ar) 9. Birthplace (State or Foreign Country) MD  10d. Inside City Limits 1 1 Yes 2 No  Citizen of What Country?  US  14. Race - American Indian, Black, White, etc.  Specify: Black
Second Part   As Second Part   As Second Part   As Second Part   As Second Part   As Second Part   As Second Part   As Second Part   As Second Part	The dical Examiner   Let a Dorrathe Greene   Let a D	8. Date of Birth Month, Day, Ye. 12/25/194  10g. pecify Yes or Noo Rican, etc.)	4c. County of Death  Washington  9. Birthplace (State or Foreign Country)  MD  10d. Inside City Limits 1 1 2 Yes 2 1 No  Citizen of What Country?  US  14. Race - American Indian, Black, White, etc.  Specify: Black
Total Reachwood Drive   Hagerstown   Washington   Some of the property of th	Funeral Director  Funeral Dire	8. Date of Birth Month, Day, Ye. 12/25/194  10g. pecify Yes or Noo Rican, etc.)	Washington  9. Birthplace (State or Foreign Country)  MD  10d. Inside City Limits 1 ▼Yes 2 □ No  Citizen of What Country?  US  14. Race - American Indian, Black, White, etc.  Specify: Black
Social Security Numbers   Colored	Funeral Director  Property of the property of	Month, Day, Ye. 12/25/194  10g. pecify Yes or No- o Rican, etc.)	9. Birthplace (State or Foreign MD)  10d. Inside City Limits 1 1 Yes 2 No  Citizen of What Country? US  14. Race - American Indian, Black, White, etc.  Specify: Black
Dispector    213-42-1256	Director  Purpose Street and Number 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10d. Zip Code 1001 Beachwood Drive 21742  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1   Yes. Specify Cuban, Mexican, Puent 1   Yes. 2 No Specify: 1   Yes. Specify Cuban, Mexican, Puent 1   Yes. 2 No Specify: 1   Yes. Specify Cuban, Mexican, Puent 1   Yes. 2 No Specify: 1   Yes. Specify Cuban, Mexican, Puent 1   Yes. 2 No Specify: 1   Yes. Specify Cuban, Mexican, Puent 2   Yes. Specify Cuban, Mexican, Puent 3   Widowed 4   Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of work in the Do NoT use retired)  15. Decedent's Education (Give kind of work done during most of work in the Do NoT use retired)  16a. Decedent's Usual Occupation (Give kind of work done during most of work in the Do NoT use retired)  17. Father's Name (First, Middle, Last)  William Allen Burnett  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Russian)	pecify Yes or No- o Rican, etc.)  16b. rking  16b. ne (First, Middle, Maid	10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
100   100	To a State   10b. County   10c. City, Town or Location   10d. Zip Code   10d.	pecify Yes or No- o Rican, etc.)  16b.  Tking  16b.  The (First, Middle, Maid	1 ☑Yes 2 □ No  Citizen of What Country?  US  14. Race - American Indian, Black, White, etc.  Specify: Black
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Security   Security	17. Father's Name (First, Middle, Last)   18. Mother's Name   18		Manufacturing
Security   Security	WITH After Bufflett  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Retailing Ad	ath Margar	
Security   Security	Wendell L. Greene / Husband 1001 Beachwood Drive,  Wendell L. Greene / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)  Wendell Company of the company of the company of the cemetery of the company of		
Security   Security	20a. Method of Disposition  20a. Method of Disposition  1 \( \text{Specify} \)  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 \( \text{Donation 5} \) Other (Specify)  Rose Hill Cemetery \( \text{O1/11} \)		
Security   Security	1 M Burial 2 Cremation 3 Removal from State    Committee   Committee   Rose Hill Cemetery   1/1		
Physician / Medical Examiner  Physic		0/2007 Ha	gerstown. MD
Physician / Medical Examiner  Physic	21. Signature of Funeral Service Licensee 22. Name and Address of Facility		
Physician   Medical   Examiner   Medical   Examiner	m && E & S N. Potomac St		
The state of the s	Physician Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  BYCOLD CONCOS  Due to (or as a consequence of):	1	
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   1   Matural   5   Pending investigation   3   Suicide   4   Homicide	W		
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   1   Matural   5   Pending investigation   3   Suicide   4   Homicide	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   1   Matural   5   Pending investigation   3   Suicide   4   Homicide	Sed signal and a s	1 ☐ Yes	2 No 3 Probably 4 □Unknown
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   1   Matural   5   Pending investigation   3   Suicide   4   Homicide	ecc		24b. Were autopsy findings available
Solution   Solution	The page of the pa	performed	death?
Solution   Solution	25. Was case referred to medical examiner?	th (Check only one)	
Solution   Solution	1   Pos 2 No Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing H		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	27. Manner of Death 28b. I fine of 2b.  28d. Describe how in	njury occurred	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	2 Accident 3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		and Number or Rural Route Number, ate)
29c. Signature and title of certifier  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)	and due to the cause	e(s) and manner as stated. and place, and due to the cause(s)
ango assence ND DOOP 5004 Represent 02, 5004	29c. License number	rred at the time, date a	Date signed (Month, Day, Year)
	and asserved MD 20005500-	rred at the time, date a	11716 911
30 Name and address of person who completed cause of death (Hem 23a) (Type, Print)  10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	30 Name and address of person who completed cause of death (Hem 23a) (Type, Print)	rred at the time, date a	4015, 30 produ
21 Date fled (Month Day Yoar) 22 Register's Signature	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	rred at the time, date a	MO15 + 200 - LAN 21214

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

The law requires that the death certificate be executed Division or Vital Records, P.O. certificate has been si rector, page 2 should I or Attending Physician: Within 24 hours after users.

To the Funeral Director: After series of the funeral Director.

Hospital

101

þ Be Completed 2 Certification:

Medical

25. Was case referred to medical

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Prebably 4 Unknown 24a. Was an autopsy

26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

2. No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

12/2007

3. Time of Death

3:01

10d. Inside City Limits

Approximate Interval Between Onset and Death

YRS

Vear

1 Nes 2 No

РМ

Hospital: 1 ☐ Inpatient Other: 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Yes 2 No

D2017-

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishna Jayaraman 28227 Three Notch Road Mechanicsville MD 20659

31. Date filed (Month, Day, Year) State JAN 12

2007

RNO

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** HARRIS ELIZABETH January 7, 2007 6:20 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Byrd Tawes Nursing Home
5. Social Security Number 6. Sex 7. Age (In vrs. Crisfield
If Under 24 Hrs. 8. Dat Somerset T. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🖾 F Months Hours Min. 85 Yrs. Director 213-22-4683 April 7, 1921 Maryland Usual Residence of Decedent релтіг. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 USA Funeral 103 Somers Cove Apartments 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: White ş 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturer 12 Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mamie Ann Somers ဂ Herman Walston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 109 Columbia Avenue - Crisfield, Maryland 21817 Linda Mister (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury 4 ☐ Donation 5 ☐ Other (Specify) 1/09/07 Salisbury, Maryland Salisbury Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. Mary Beth Bradshaw—Pruitt

23a. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CANCER LUNG METASTATIC **Examiner** Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 Yes 2□ No 3 Probably 4 ☐ Unknown ASCV D \$ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) ဥ 1 Yes 2 No this Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 27. Menner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide filled 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 48098 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRISFIELP, MD, 21817 201, HALL HIGHWAY KARUMBUN ATITAN ·VITAY 31. Date filed (Month, Day, Year) 32. Regierar's Signature State Registrar JAN 0 9 2007

**DHMH 16 Rev 6/95** 

Box 68760.

P.O.

Records,

of Vital

Division

		1	FOR	epartment of Health and N Certificate of Death	Mental Hygiene	007 01333
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Ruth Elizabeth Hambrick		Month 01/05/	200 <sup>Year</sup> 1:19P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. Co	ounty of Death
	LXUIIIII		133 Yawl Drive	Ocean City	Wo	rcester
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months   Davs   Hours   Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		458-36-5127 1 M ALXF 81 Y	rs.	12/04/1925	WV
-3	2	+	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	sho sho	5	MD Worcester Ocean			1 X Yes 2 ☐ No
	28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citize	n of What Country?
3	NIII NIII		133 Yaw1 Drive	21842	USA	
-	iled within 72 hours after deeth with the maryland Hygiene, then "naturel", or Itema 23a or 28a-f show the then "naturel", or Itema 23a or 28a-f show ent, the Medical Examinar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp		. Race - American Indian,
	iter of	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto		Black, White, etc. pecify: White
3	orsa	by	XX Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Sį	Decity: WILLLE
Baitimore, maryland 21213-0036	2 ho	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind	of Business/Industry
V .	inin a	lg l	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
7	ygien yerth t, the	Co		rvice Representative	e Tele	phone Company
	be filed within 72 hours after deeth with the Madylar Hydjene. Ad other than "natural", or itema 23a or 28a-f show and other than "natural" as went, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)		ı Lester	inane,
<u> </u>	2 should be filed within and Mentel Hygiene. Is marked other than aumatic event, Ins Mi	၉	Bert C. Gregory	Mailing Address (Street and Number or Ru		Court State Zin Code
	ges 1 and 2 should it of Health and Mer if item 27 Is marke or other traumatic					
ů,	1 and 2 Health tam 27 other tra			33 Yaw1 Drive Ocean Disposition (Name of , crematory or other place)		tion - City or Town, State
<u>ס</u>	Pages nent of h nnt: If its ury or o		1 Burial 2 M Cremation 3 L Removal from State		08/2007 Frank	ford DF
	it. Partitions in injury	. 8	4 Donation 5 Other (Specify) Cape H			
g	permit. Page Department of Important: If any injury or once.		* Tage and I To all hosts	22. Name and Address of Facility But 108 William Street	bage Funeral	Home
			Ga. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heave failure. List only one cause on each line.			Approximate Interval Between
				1		Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the conse			
	Examiner		1) +			
	F	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):		
	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.	lonia		
Ś	exec en an rial-tr	Exa	resulting in death) Last Due to (1 a conseque ce o	of):		
8/60,	The law requires that the death certificate be executed te hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dlcal	d			
9	ng ph ng ph as th	Med	IF FEMALE:		-	
Rox	eath certific attending pl	Physiclan/Me	23b. Was decedent pregnant  1 Live birth 2 Fetal death	3 □Ectopic pregnancy	23	d. Date of delivery  Month Day Year
	the al	sici	1 🗌 Yes 2 🗐 No 9 🗍 Unknown	5 Other (specify)		
P.O.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
ds,	signe signe d be d	d b	Nicotine addiction	, , , , , , , , , , , , , , , , , , , ,	1 Tes 2 🗆	No 3 Probably 4 Unknown
Ö	been been shoul	Completed	Octobertos		24a. Was an	24b. Were autopsy findings available
ě	hes hes 3e 2	ם	0,000		autopsy performed?	prior to completion of cause of death?
ā	n: Th ficete	င်	OF Was seen referred to marked	GC Blace of Do	1 Yes 2 No _	1 ☐ Yes 2 ☐ No
<del>=</del>	Physician: r this certifice ral director.	00	25. Was case referred to medical examiner?  1   Yes 2   No	Other	Iome 5 Residence 6	□Other (Specify)
ō	Phy r this aral d	5.	27. Manner of Death 28a. Date of Injury 28b. 1	Time of 28c. Injury at	28d. Describe how injury	
o	Attending in death.	흝	1 ☑ Natural 5 ☐ Pending (Month, Day Year) In 2 ☐ Accident investigation	njury Work?  M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	Attence death	100	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
á	s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		2, 3	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only 2 Medical Examiner: On the basis of examination an	e, death occurred at the time, date and place	e, and due to the cause(s) a	nd manner as stated.  blace, and due to the cause(s)
	the H in 24 the F iplete	Medical	one) and manner stated.			
	To To	2	29b. Signature and title of certifier	29c. License number	290. Date	signed (Month, Day, Year)
•			Jak Jemes mo	7 7825/	///	10/
	BA5		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	Deges Cote	MD 11842
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	Daster clary		7
	Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 0 8 2007  32. Registrar's Signature	Aprile		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0155 AM 3 trances 1 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury

Salisbury

Min. Coastal Hospice At the Lake WICOMICO Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛛 F Months Hours Min Yrs Director 216-64-9022 70 June 12, 1936 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No MD Worcester Girdletree 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6122 Taylor Landing Road 21829 Funeral U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white ģ 3 ☐ Widowed 4 StDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Poultry Company 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill lealth and Mental H m 27 is marked oth Be Clarence Wilson Ardis ပ Dolly Holland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 James Thomas Hooks 5524 Bluebird Lane Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of h Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Springhill Cemetery Jan. 5, 2007 | Girdletree, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street Delmar, DE 19940 23a. Part1. Enter the di shock, or hear fai that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) METATATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as t IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9□Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Yo 24a. Was an certificate has autopsy 2 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 10917 00053410 2m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARROWWOOD CT. 26266 31. Date filed (Month, Day, Year) State JAN 0 5 2007 Registrar

			1 - State of Maryland / Dep	artment of Health and Nertificate of Death	Mental Hygiene	
	Di		Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
	Physici /Medic		STANLEY DOUGLAS HOPKINS		01-02-200	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
		.5	Fort Washington Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Fort Washington    If Under 1 Year   If Under 24 Hrs.		ince George's
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday  Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year, 05–18–1944	Birthplace (State or Foreign Country)
			Usuel Residence of Decedent		05 10 1544	Virginia
	rylan	_	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	Ba-f s	Director	Maryland Prince George's Fort Was	shington		1 BYes 2 No
	vith th	Dire	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country? USA
	sath v	era	20 Pates Drive           11. Marital Status         12. Was Decedent Ever in U.S.         13.	20744	acity Vac as No	14. Race - American Indian,
	Iter d	Funeral	1 □ Never Married 2 Married 12 Never Married 2 Narried	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2√√No Specify:		Specify: Black
20	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23e or 28e-f show ta Maulcal Exerciter mal Le Duttied at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of work	ing 16b. K	Kind of Business/Industry
2	within ene.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	1	Post Office
Maryland 21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event, It s Madical Extended at		12th +04 Pos	tal Worker	e (First, Middle, Maider	
and	2 should be filed v n and Mental Hygie 'Is markad other t raumatic evant, IL	Be	UNKNOWN	Bertha H		r Surname)
7	ges 1 and 2 should be t of Health and Mental If item 27 Is marked o or other traumatic eve	5		ing Address (Street and Number or Run	<u> </u>	or Town State Zin Code)
	nd 2 suith ar			ates Drive Ft. WA	_	
re,	is 1 and 2 of Health item 27 l		20a. Method of Disposition 20b. Place of Disposition			ocation - City or Town, State
E	Page nent c int: If			11 Cemetery 01-0	6-07 Suit	tland, Maryland
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or ot once.			2. Name and Address of Facility edar Hill FH 4111	PA Ave. Sui	itland, Md. 20746
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	~		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or all a consequence of):			
	-Adminoi	J.,	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	nsit	Examiner	cause. Enter Underlying			
<u>,</u>	execun n and ial-tra	Exar	that initiated events c. Due to (or as a consequence of):			
8760,	death certificate be executed to attending physician and at for use as the buriat-transit	dical	d			
9	ntifica ng ph as th	Medi	IF FEMALE.			
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3.	□Ectopic pregnancy		23d. Date of delivery  Month Day Year
о. П	the dea y the at sched to	/slcl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month Day rear
4	÷ > ○	Ph	Part II. Dther significant conditions contributing to death but not resulting in the	inderlying cause given in Part I	23e Did tobacco	use contribute to the cause of death?
Records,	se g eq	d by	Colon Concer	,,	1 ☐ Yes 2	/
COL	> 0 0	Completed	Band Obstruction		24a. Was an	24b. Were autopsy findings available
Re	The law ate has boage 2 st	d mc	Brown Mat et lis		autopsy performed?	prior to completion of cause of death?
Vital	ician: Th certiticate ector, pag	a	25. Was case referred to medical	26 Place of Deatl	1 Yes 2 No ∩ (Check only one)	1 Yes 2 No
	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatie	Other	me 5 Residence	6 ☐ Other (Specify)
0			27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury 1 ☐ Natural 5 ☐ Pending (Month, Day Year)	of 28c. Injury at Work?	28d. Describe how inju	ry occurred
sio	Attanding r death. actor: Atte	catle	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division of	in the	Certification:	4 Homicide  28e. Place of Injury - At home, farm, so building, etc. (Specify)	reet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely tilled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the sauss/-	) and manner as stated
	a Hos 24 h a Fun etely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	expecting at the time, date and place, investigation, in my opinion, death occurr	ed at the time, date and	d place, and due to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely tilled	Me	29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
)			Alan A. Overhundon	1.D.D.3.2.800	1 -	-2-2007
	(12)		30. Name and address of person who completed cause of death (Ijen 23a) (Type	, Print)		3
				ringston Rd #209	5 Ft. Wash	ington, MD 20744
	Sta Registr		JAN 0 5 2007 See D. Special D. Sp	<i>j</i>		
			The same of the sa			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jan. 1, 5:00 P M **Physician** 2007 William Elmer Hall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Adelphi Hillhaven Nursing Home 
 Under 1 Year
 If Under 24 Hrs.

 Onths
 Days

 Hours
 Min.

 Apr. 26, 1
 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 17€ M 2 ☐ F 91 1915 McComas, 232-44-2202 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 No Prince George's Adelphi Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 USA 3210 Powder Mill Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 / 10 Black, White, etc. 1 XYes 2 No 1/1930 If Yes, Give Year or Dates: 11/1945 within 72 hours after 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 ☑ No Specify: Specify: Baltimore, Maryland 21215-0036 δ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Department Technician 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H lent: If Item 27 Is marked of George Hall Pearl Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7119 Garland Ave., Takoma Park, MD 20912
of Disposition (Name of Date 20c. Location - City or Town, State Robert Stoltz - Friend / POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6 permit. Page Department o Importent: If any injury or once. Monte Vista Park Cemetery Jan. 11,2007 Bluefield, WV 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 4739 Baltimore Ave. 21. Signature of Funeral Septice License Hyattsville, MD 20781 Gasch's Funeral Home, P.A. THULL or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist day one cause on each line. Approximate Interval Between Onset and Death 23a ant. Enter the disease, shock, or heart failure. L Immedia Cause (Final disease or condition resulting in death) 3 days Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner Years Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? ō 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No Ö been signed by the should be detached 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Records, 1 Yes 2 No 3 Probably 4 Unknown Renal Insufficiency Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 28 No 1 ☐ Yes 2. No certificate of Vital 26. Place of Death (Check only one) director 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4\overline{Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 1 ☐ Yes 2 🖾 No After this 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Division Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospitel or At within 24 hours after of To the Funerel Direct 4 - Homicide > Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ZE Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number Koma Mul address of pers in who d cause of death (Item 23 n (Type, Print) Lockwood M.D tinulis homa 31. Date filed (Month, Day, Year) JAN 0 5 2007 32. Registrar's Signatur State Registrar

		State of Maryland / Dena	rtment of Health and Ment	-	_
		a POI	tificate of Death	ar riygieri Rea. N	0 2 0 = - 1 0 0 0
		Decedent's Name (First, Middle, Last)	2. Da	ate of Death	3. Time of Death
Physici: /Medic		Alice Marie HUTZELL	J	onth $Un$ .	Day Year 12:07 M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
*.		Washington County Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Hagerstown If Under 1 Year   If Under 24 Hrs.   8, Da	ate of Birth	Washington
Funeral Director		215-64-0252   1 M 2 M F   65   Yrs.	Months Days Hours Min. (M	lonth, Day, Yea	
		Usual Residence of Decedent		C. Z 19	
arylar show dat	'n	10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M 28a-f lotifie	Director	Maryland Washington Hage	erstown 10f. Zip Code	100.0	Citizen of What Country?
72 hours after death with the Maryland natural; or items 23a or 28a-f show die al Examiner must be notified at		11800 Partridge Trail	21742		USA
death	Funeral		/as Decedent of Hispanic Origin? (Specify Y Yes, specify Cuban, Mexican, Puerto Rican,		14. Race - American Indian,
after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1	Tes, specify Cubari, Mexicani, Puerto Hicani,  ☐ Yes 2☑ No Specify:	, etc.)	Black, White, etc.  Specify: White
hours tural";	d by	3Å Widowed 4 □ Divorced Year or Dates:	ent's Usual Occupation	166	
in 72 in 72 in at	Completed	(Specify only highest grade completed) (Give k	cind of work done during most of working O NOT use retired)	166.	Kind of Business/Industry
filed within Hygiene. other than '	mo	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		Her own home
be filed within 72 ho that Hygiene. In other than "natu event, the Medical	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First	, Middle, Maide	en Surname)
ould to Ment	ပို	John Henson Line	Hattie Mae		
12sh thand 7ism traum			Address (Street and Number or Rural Rout		
Heall Heall tem 2		Charles Hutzell, Jr Son 16-C  20a. Method of Disposition  1 Period 2 Formation 2 Personal from State  20b. Place of Dispos cemetery, crem	Wayside Avenue, Hage		, Md . 21/40 Location - City or Town, State
permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Important: If item 27 is marked other than "rn any injury or other traumatic event, the Medione.			n Crematory 1/9/07	Нас	gerstown, Maryland
mit. I partm portai		110,802.000			uneral Home
Pe E E		Kolet Stone	15 E. Wilson Blvd. H	lagerst	own, Maryland 21740
		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or resp	iratory arrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)			4 week
/Medical Examiner		Due to (or as a consequence of):	P. n. 12 and		
24	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ing Disease		ys
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
be executed sician and burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
cate b physic the b	dical	<b>d</b>			
death certificate leath certificate leath certificate leath and ing physical for use as the terminal f	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery
death atter	iciar	in the past 12 months?  1 Ves 2 No.  1 Ves 2 No.	Ectopic pregnancy Other (specify)		Month Day Year
at the by the tache	hys	9 □ Unknown 9□ Unknown			
The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I. 23		o use contribute to the cause of death?
w requir been si should	Completed	Oil to		1 Yes	2 No 3 Probably 4 Unknown
has the ge 2 s	mpl	Capeles melulus	24	4a. Was an autopsy pertormed?	24b. Were autopsy findings available prior to completion of cause of death?
	မ လ	25. Was case referred to medical	26. Place of Death (Che	☐ Yes 21941	
Physician: this certifica	o B	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	Others		6 □Other (Specify)
. <b>D</b> ja ja	on: T	27. Manner of Death  1 1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  Injury		escribe how inj	
tendi leath. tor: A the fu	catic	2 Accident investigation	M 1 Yes 2 No		
or At after d Direc	Certification:	4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide		cation (Street a ity or Town, Sta	and Number or Rural Route Number, ate)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 15 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and du	ie to the cause	(s) and manner as stated.
he Ho in 24 l he Fu pletel	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invented and manner stated.	estigation, in my opinion, death occurred at t	the time, date a	and place, and due to the cause(s)
To t	Σ	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month, Day, Year)
		, , ,	044 996	/	-5-01
9H-4		30. Name and address of person who completed cause of death (Item 23a) Type, F	kass Pd Br	meho	10 11/ 2/7/3
Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	9	1,000	100 300111
Registr	ar	JAN 0 9 2007 Janeer B. P.	Aires		

			1 - For State Registrar	State of Maryland / Department / Ce	rtificate of Death	Reg. N	
	Physici /Medic		1. Decedent's Name (First, Middle, L Bonne F	HSEY		2. Date of Death Month D	ay Year 3. Time of Death 5:12 a.m
	Examir Funeral Director		5. Social Security Number 6.	ve street and number)  Y Land Medical Centre  Sex 7. Age (In yrs. last birthday)  1 M 2 \$ F 66 Yrs.	4b. City, Town, or Location of Death  Path no re  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yeal Oct. 12	
	land t		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	peation	000. 12	10d. Inside City Limits
	death with the Maryland ome 23s or 28s-f show it must be contilled at	Director	Maryland Washing	gton Maugans			1 ☐ Yes 2X No
	h with 1		13643 Village Mi	Il Drive	10f. Zip Code 21767	10g. C	citizen of What Country?
030	Jwithin 72 hours after deat jiene. r then "natural", or iteme 2 tre Medical Exambrant.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	ISA  14. Race - American Indian, Black, White, etc.  Specify: White
0500-6171	within 72 ho ene. then "natur te Medical	Completed	15. Decedent's Elementary/Secondary (0-12)	ade completed) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	16b. l	Kind of Business/Industry
and 2	tat Hyg d othe	Be	11 17. Father's Name (First, Middle, Las	•		e (First, Middle, Maide	
Maryi	d 2 should th and Men 7 ie marke traumatic	ဥ	Ernest L. Wolfens 19a. Informant's Name/Relationship		Virginia ng Address (Street and Number or Rura	a Ruth Brev	
	as 1 and 2 of Health a item 27 is r other tra		Fred A. Hiser, Si  20a. Method of Disposition  1 🕅 Burial 2 🗆 Cremation 3	20b. Place of Dispo	3 Village Mill Driversion (Name of matory or other place) 1/8/	20c. l	DSV111e, Md. 21767 Location - City or Town, State
pallimore,	permit. Page Department i Important; if any injury or once.		4 □ Donation 5 □ Other (Spec	nsee	wn Memorial Park 2. Name and Address of Facility N 15 E. Wilson Blvd.	Minnich Fur	
	Physician		Immediate Cause (Final disease or condition	nplications that caused the death. Do not ent		or respiratory arrest,	Approximate Interval Between Onset and Death
ı.	Medicale be executed of physicien and as the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hy per fen 5 i  Due to (or as a consequence of):  A fine rols was  Due to (or as a consequence of):  Due to (or as a consequence of):	080		
.C. BOX 0	ie death cert the attendin hed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
cords, r.	w requires thet the been signed by should be detack	þ	Part II. Other significant conditions	contributing to death but not resulting in the u	nderlying cause given in Part I.	\1	use contribute to the cause of death?  No 3 Probably 4 Unknown
ב ב	The law ete hes b page 2 sl	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
VILA	reician s certifi director	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 2 ER/Outpatient	26. Place of Death	n Check only one	a (70)
DIVISION OF	the Hospital or Attending Physician: The hin 24 hours after death. The Funeral Director: Atter this certificate he pplately filled in by the funeral director, page	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury Injury		28d. Describe how inju	
2	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the		4 Homicide determined	building, etc. (Specify)		City or Town, Stat	
	the Hosp vin 24 hor the Fune upletely fix	ledical	one) 2 Medical Exe	hysicien: To the best of my knowledge, death miner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date an	nd place, and due to the cause(s)
1	With To t	Σ	29b. Signature and title of certifier	mo	29c. License number AM 4176435 #167	1	ate signed (Month, Day, Year) M 05 2007
ۈ	4-5		30. Name and addregof rson who was a second of the second		Print) Greene St Ba	thinwore,	mO 21201
	Sta	τe	S. Date field (Month, Day, 1941)	32. Registrar's Signature	470		

hours after

Maryland 21215-0036

Baltimore.

The law requires that the death certificate be executed

Box 68760,

o.

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Records,

Division of Vital

To the Hospitel or Attending Physician:

State Registrar

31. Date filed (Month, Day, Year)

JAN 0 8 2007

30. Name and address of person who completed cause of death (Item 23a) [Type, Print) Behne

32 gistrar's Signature

Mizahaa

016479

8/07

ason Duwan Hugh	1- For State Registrar	ertificate of Death	Reg No 2007 0134
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)     Jason     Duwan	Hughes 2. Date of D Month January	Death Day Year O445 hrs
	4a Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral	RT. 5 North of Bryan Town Road  5. Social Security Number 6. Sex 7. Age (In yrs.	Bryantown  last birthday)   If Under 1 Year   If Under 24Hrs   8. Date of	Charles  Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	215-17-7310 1X M 2 F 19  Usual Residence of Decedent	No. 10 Paris 1 Paris 1	21, 1987 Country Maryland
* any	10a State 10b. County 10c. Cit	y, Town or Location	10d Inside City Limits
yland a-f shov t once.	Maryland Charles  10e. Street and Number	Waldorf	1 Yes 2 X No
th the Maryland  23a or 28a-f sho notified at once al Director	1513 Bryan Court	10f. Zip Code 20602	10g. Citizen of What Country?  USA
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 X Never Married 2 Married Armed Forces?  1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc
urs afte	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15 Decedent's Education (Specify only highest grade completed)	1 Yes XXX No specify  16a. Decedent's Usual Occupation (Give kind of work done	Specify: White  16b Kind of Business/Industry
5-0036 ed within 72 hour tygiene, other than "natu ohe-Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired)  Roof Walker	Poofina
5-003 ed withi ygiene other the he Med	12 17. Father's Name (First, Middle, Last)	18 Mother's Name (First, Middl	Roofing e, Maiden Surname)
21215-0036 Juld be filed within 7 Mental Hygiene marked other than cerent, the Medica	Michael Eugene Hugh		arie Rider
MD 21 and 2 should alth and Me m 27 is ma aumatic en	19a Informant's Name/Relationship (Type Print)  Michael E. Hughes/ Father	19b. Mailing Address (Street and Number or Rural Route N 7155 Swann Gate Place, Hug	hesville, MD 20637
Baltimore, permit Pages I an permit Pages I an Department of Hea Important: If itee Important of the Injury or other tr	1 XXBurial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)  Tinity Memorial Grds 1/11/200	20c. Location - City or Town, State  7 Waldorf, MD
Baltir Permit P Departme Importar injury or	21 Signature of Funeral Service Licenses	22 Name and Address of Facility Brinsfield-Echols Funer	al Home, P.A. 20622
Physician	Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	30195 Three Notch Rd	Charlotte Hall, MD  arrest, shock, or heart   Approximate Interval
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Drowning and Hypothe Due to (or as a consequence		Between Onset and Death
5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	of):	
ted Insit Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence		
760, icate be executed the burial - transit	d UNPENDED AMENDED		
760, icate be physicia the buria	IF FEMALE: 23c. If yes, outcome of pre	gnancy	23d Date of delivery
ox 68 eath certif attending for use as	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of d 9 Unknown	2 Fetal death 3 Ectopic pregnancy leath 5 Other (Specify)	Month Day Year
P.O. B s that the d gned by the e detached i by Phy	Part II. Other significant conditions contributing to death but not		tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
ords, F w requires is seen sign should be o		24a. Wa	as an 24b. Were autopsy findings available
Division of Vital Records, P.O tal or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director. Page 2 should be detacted in the funeral of the Completed by Fartification: To Be Completed by Fartification:			prior to completion of cause of death?  5 2 No 1 Yes 2 No
Vital Rec	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2	26.Place of Death (Check only one)  ER/Outpatient 3 DOA Other Nursing Home 5	Residence 6 ✔ Other: Scene
n of Viding Physical After this funeral difference on: To	27. Manner of Death  28a. Date of Injury  1 Natural  Agricultural  1 Natural	28b. Time of Injury 28c. Injury at Work? 28d. Describ	ne how injury occurred auto drowned and exposed to cold
Division o Division o Bispital or Attending 24 hours after death. Funeral Director: After telly filled in by the funeral Certification:	2 Accident Investigation	nome, farm, street, factory, office building, etc. 28f. Location	(Street and Number or Rural Route Number, City
Di Di Sepital o hours at meral I. y filled	4 Homicide determined (Specify) Swamp		d Route 5 North Bryantown Road, Bryantown
To the How within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and manner stated	dge, death occurred at the time, date and place, and due to the ca and/or investigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)
) [5	29b Signature and title of certifier  him him, him	29c. License number  O.C.M.E.	29d Date signed (Month, Day, Year)  January 7, 2007
	30. Name and address of person who completed cause of death (Iter		1
CANA		1 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 2007 Registrar's Signat	South	
DHMH 17 Rev 1/2001		ORIGINAL	

			Please	Type or Pr					-		_		
		For State Registrar		State of N	/laryland /		artment of <i>rtificate of</i>	Health and N Death	Mental Hy	giene Reg. No		7 01:	342
Physic	ion	1. Decedent's Nam	ie (First, Middle, L	ast)					2. Date of De	eath Da	y Yea	3. Time of	Death
Physic //Med				le Hathev					Jan	0.	3 200	07 03	58 <sup>M</sup>
Exami	ner	· · · · ·		ive street and numbe	,			or Location of Death		4c.	. County of De	eath	
		Carroll 5. Social Security N		cal Cente	er Age (In yrs. last b	oirthday)		stminste	r 8. Date of Bi	rth	Car		v Foreign
Funeral Director		212-07-		1 □ M 2 □ 🏋	90	V	Months Days		(Month, Da	ay, Year)		irthplace (State o Country)	
70		Usual Residence o	f Decedent						Sept	10	1910		MD
anylar show dat	_	10a. State	10b. County		10c. City, To	wn or Lo	ocation					10d. Inside Cit	•
he Ma 28a-f	Director	MD		roll		Wes	tminste	er		10 00		1 □ Yes	2 X NO
with t		10e. Street and Nu		D'1			10f. Zip Code			10g. Cit	izen of What		
death with the Maryland ims 23a or 28a-f show r must be notified at	Funeral	11. Marital Status	ittiest	own Pike		13.	Was Decedent of	21158 Hispanic Origin? (Sr	ecify Yes or No	)-		JSA nerican Indian,	
after d	F		ried 2 Married	Armed Forces	s?	- 1		Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)		Black, Wi		
ral"; o	by .	3 XWidowed	4 ☐ Divorced	If Yes, Give Year or Dates			1⊡Yes AXTNo	Specify:			Specify:	White	
2-003 72 hours 'natural'; dical Exa	Completed	(Spe	15. Decedent's E	Education rade completed)	16	a. Dece	dent's Usual Occu	upation of during most of work ed)	king		ind of Busines		
d < 1 < 1   C   C   C   C   C   C   C   C   C	g	Elementary/Seco	ondary (0-12)	College (1-4o	r 5+)			*				pkins Physic	e Tai
Hygie Hygie Ither t		10 17. Father's Name	(First, Middle, Las	at)		Ca	feteria	Manage:	r e (First Middle			Inysic	э пах
id be i lental i ked o	o Be		Innerst	,					trude		,	^1 d ~	
Taryta 2 should and Men is marke	은	19a. Informant's N			19	9b. Maitii	ng Address (Stree	nt and Number or Ru					
and 2 ealth a m 27 is		Margare	t Foers	ter/daud				tlestow				er, MD	2115
of H of H rot		20a. Method of Dis	position		20b. Place		osition (Name of matory or other pla		Date 3/2007	20c. Lo	ocation - City	or Town, State	کیای
cartification rates partment of portant: If it portant: If it y Injury or cice.			5 Other (Spec	□Removal from Stat ify)	ie			orial Ga		Ma	rriot	sville	. MD
Dalling  permit. Page Department. Important: if any injury o		21. Signature of F	0/00	11 -		P	2. Name and Addr Pritts ]	Funeral	Home a	nd (	Chane	l D A	
		23a. P 111. Enter	the disease, or cor	mplications to t caus y one cause on each	ed the death. Do	not en	er the mc e or dy	mg, sum a da lac	Road	esti	minste	r Approximate	1157
Physician		Immediat Se se	(Final				fore non					Onset and D	veen eath
/ /Medical		resulting in death)		a. Due (or a	e or dial		LEGACTION					1	
Examiner		Sequentially list co	onditions	b. Asy	stole as a consequence								
p #	iner	Sequentially list co if any leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Due to Mr a	is a conse juence	e of:						P704	
ecute and	Examine	that initiated events resulting in death)	S E	c. Sev	ere A	ONDE	Stens	SIS				Syrs	
be ex ician a burial-				d. Syste		,	scleros					54100	
oo/ ficate g phys	gic			d. <u> </u>	ante of	1000	35611103	13				3415	
ath certi	n/Me	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, outcom							23d. Date of d	elivery	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	in the past 12 1 ☐ Yes 21 9 ☐ Unknown	months?		2 Fetal dea at time of death		□Ectopic pregnand □ Other (specify) _	су			Month	,	'ear
that the ed by detac		Part II. Other signi	ficant conditions	contributing to death	but not resulting	in the u	nderlying cause gi	iven in Part I.	23e. Did 1	obacco u	use contribute	to the cause of de	eath?
law requires that seem signer 2 should be	d by								1 🗆	Yes 2	□ No 3□	Probably 4 🔀	Inknown
aw rec	Completed								24a. Was	an	24b. Were	autopsy findings a	available
The late had age 2	E O								auto perfo	psy ormed? 2 <b>19</b> No	prior to	completion of ca	use of
VILCIIII	0	25. Was case refe	rred to medical	L				26. Place of Deat			1 □ Y∈	:S 2   140	
Physic Physic rthis ce	To B	examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpa	tient 2 ER/C	Outpatier	nt 3□DOA Ot	her: 4 Nursing Ho	ome 5 Resi	dence (	6 □Other (Sp	ecify)	
Ing P		27. Manner of Deal	th 5 ☐ Pending	28a. Date of In (Month, L	njury 28b. <i>Day Year)</i>	. Time o	f 28c. Inju	ury at ork?	28d. Describe	how injur	y occurred		
tendi tor: A	cati	2 ☐ Accident 3 ☐ Suicide	investigation	he				Yes 2 No					
or Al	Certification:	4 ☐ Homicide	determined	Zee. Place of I	etc. <i>(Specify)</i>	rarm, str	eet, factory, office		28f. Location (	Street an wn, State	d Number or i	Rural Route Numl	er,
spital		29a. Certifier	1 Certifying P	hysician: To the bes	st of my knowledg	ge, deat	h occurred at the t	time, date and place,	and due to the	cause(s)	and manner	as stated.	
thin 24 h	Medical	(Check only one) 29b. Signature and	2 Medical Exa	aminer: On the basis and manner:	of examination a	and/or in	vestigation, in my	opinion, death occur se number	red at the time,	date and	d place, and d	ue to the cause(s)	
F ₹ F 8	-			In MO				8736				oth, Day, Year)	, -,
MIL		30. Name and add	ress of person who	completed cause of	death (Item 23a)	) (Type	Print)			Jan	inery	, 200	7
[ -		Zalman	v M. Kakr	MD, L	112 Ma	leal	m Blud	Suite 30	34, W	287m	inster	MD 200	57
	ate	31. Date filed (Mor	nth, Day, Year)	2007 32. Reco	strar's Signature		,						
Regist	rar		JAN U 4	2001	elve &	1	miles						

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2007 **Physician** Martha Emma Johann 5:15 Jan. Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hagerstown Beverly Healthcare If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 08/08/1916 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**X** F 90 190-18-5053 PA Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **ahow** r than "natural", or Itama 23a or 28a-f ahov the Medical Examiner must be notified at Hagerstown 1X Yes 2 No MD Washington by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21740 US 7 E. Washington Street, Apt. 810 death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 end 2 should be filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home 12 Homemaker of Health and Mental Hygie If Itam 27 ia marked other i ir other traumatic avant, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle (unk) Cornelius (unk) Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 1071, Hedgesville, WV 25427 Jeffrey Johann / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Peges Inent of Hant: If Ita 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 01/10/2007 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home Ty 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alter Sclerol **Physician** divasular desca 19/10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien end for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autoosy performe 1 Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Hospital or Attending 5 Pending Injury 2 🗌 No 1 Tes death. investigation 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28365 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) A12 Aw 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 09 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200<sup>4</sup>7° Russell Winfield Jordan January 7:30 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 217 N. Locust St. Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**XM 2□ F Days Hours Director Yrs 218-62-8080 June 15,1960 Maryland 46 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "naturel", or iteme 23e or 28e-f show traumatic event, the Mudical Examinar must be notified at XXYes 2 □ No Maryland Washington Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 21740 USA 217 N. Locust St. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2XX No If Yes, Give Year or Dates: 1 Never Married Married 1 Yes 2 No þ 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Loader Siding Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robinson Russell Jordan Susan Marie Dale 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum 2002. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele A. Jordan - Wife 217 N. Locust St. Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Lawn Mem. Park | Jan.9,2007 Hagerstown, Maryland 21. Signature of Funeral San Ostorne Humerally Home, P.A. 425 S. Conococheague St. Williamsport, Maryland Enter the di or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Disease Chrmic tive obstruc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of: bete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Congestive Vital 1☐ Yes 2☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification Hospital or Attending 1 Natural 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after deati To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doc 57285 MD 01/05/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 24 N. Walnut St., 4102, WH-2 a. Koilpillai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 0 8 2007 DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month George Jay Joseph 1, 2007 5:05 P M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/07/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 ☐ F 119-24-7985 87 Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits al Hygiene. other than "natural", or Items 23a or 28a-f shov vent, the Medical Examiner must be notified at Maryland Montgomery Chevy Chase 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7601 Rossdhu Ct. 20815 U.S.A. 2 should be filed within 72 hours after death v n and Mental Hygiene. Is marked other than "nature." Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1⊠Yes 2□No World If Yes, Give Year or Dates:War II 1 ☐ Never Married 2 Married 1∐Yes 2∏xNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Publisher Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e Mendel Joseph Lena Jaspan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a important: If Item 27 is any Injury or other trains 7601 Rossdhu Ct. Chevy Chase, MD 20815 Ann Friedman Joseph / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) em 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance Jan 4 2007 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 2 Days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each of cause (Disease or injury that initiated events resulting in death) Last Aspiration Pneumonia Due to (or as a consequence of): 2 Days Examine Dysphagia 1 Week Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Renal Failure, Multiple Myeloma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2X No Be Certification: To

sician and burial-trans ed by the attending physician detached for use as the buria 

ours after death.

neral Director: After this certifics
filled in by the funeral director, i

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with the

Baltimore, Maryland 21215-0036

Pages '

To the Hospital within 24 hours at To the Funeral C

Medical

29a. Certifier

(	Was case referre examiner? 1 □ Yes 2√ N		Hospital:	2 ER/Outpatient	3 🗆 (	Othor:	ath Check onlone  Home 5 Residence 6 Other (Specify)
	Manner of Death I∭Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day Y	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury building, etc. (	- At home, farm, stree Specify)	et, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

🏗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of pertifier

29c. License number

29d. Date signed (Month, Day, Year)

lanuan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brent A. Berger MD 10215 Fernwood Rd. Bethesda, MD 20817

State Registrar 31. Date filed (Month, Day, Year) **JAN 03** 2007



and manner stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

ame (If not institution IAL HOSPI' curity Number 4-8861 ence of Decedent	DRIAN J  on, give street and number)  TAL  6. Sex  1 M 2 F	ge (In yrs. last b	oirthday) Yrs.	4b. City, Town, or  CUMBERL,  If Under 1 Year  Months Days	r Location of Death  AND  If Under 24 Hrs.  Hours Min.	2. Date of Deal Month 01	Day 07	Year 2007 yof Death	1405					
ame (If not institution IAL HOSPI' curity Number 4-8861 ence of Decedent 10b. County Garre und Number Summitt Dr tatus	nn, give street and number)  TAL  6. Sex  1 □ M 2 □ F  7. As	ge (In yrs. last b 81	oirthday) Yrs.	CUMBERL If Under 1 Year	AND If Under 24 Hrs.	01	4c. Count	2007 by of Death	1405					
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	Tive			21561			United	States	í					
or Married of When	12. Was Decedent Armed Forces	?	13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ice - American I ack, White, etc.						
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Name (First, Middle,	•				18. Mother's Name									
Albert	t Jachows	ski, Sr.			Elsie		Schmid	t						
ant's Name/Relations				g Address (Street	and Number or Rura				de)					
ara J. Oxe	enham, Daught	ter 8	8 Ros	ger Way,	Cumberlar	nd, MD	21502							
of Disposition		20b. Place	of Dispos	sition (Name of natory or other place			20c. Location	- City or Town,	State					
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Cause (Final condition death)  Ilist conditions, go to immediate or Underlying asse or injury events death) Last	b. Cere Due to (or as	a consequence	e of): e of):		orrhad	dent			rset and Deat					
ecedent pregnant past 12 months? ss 2 \( \square\) No nknown		e pf pregnancy 2 □ Fetal deat at time of death		Ectopic pregnancy Other (specify)	/			ate of delivery lonth Da	y Year					
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						24a. Was a autops perfori 1□ Yes	med?	. Were autopsy prior to comple death?	findings avai etion of cause					
se referred to medica					26. Place of Death									
2₩ No	Hospital: 1 Inpati	ient 2 ☐ ER/O	Outpatien	t 3□ DOA Oth	er: 4 Nursing Ho	me 5 Reside	ence 6 □Ot	ther (Specify)						
of Death µral 5 □ Pendir ident investi	igation		Time of Injury	28c, Injur Worl	yat k? Yes 2 □ No	28d. Describe ho	ow injury occu	rred						
3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)														
cide 6 Could	I Examiner: On the basis	of examination a	ge, death and/or inv	occurred at the tir restigation, in my o	me, date and place, ppinion, death occur	and due to the c red at the time, d	ause(s) and m late and place	nanner as state , and due to the	d. e cause(s)					
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cide	1 Certify 2 ☐ Medica	2 Medical Examiner: On the basis and manner s	2 ☐ Medical Examiner: On the basis of examination and manner stated.	2 ☐ Medical Examiner: On the basis of examination and/or invarient and an examination and for invarient and for invarie	2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my of an examination and or investigation, in my of and title of certifier and title of certifier 29c. Licens	2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  and title of certifier 29c. License number	2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, or and manner stated.  29c. License number	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.  29c. License number 29d. Date sign	and repanner stated.					

State Registrar

DHMH 17 Rev 1/2001

Frederick, Maryland

21701

801 Toll House Avenue,

W

32. Resstrar's Signature

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

M.D.

8 2007

Sajjad Aziz

JAN 0

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JEAN JANUARY 200<sup>Year</sup> M JONES 9:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL PREDERICK Under 1 Year If Under 24 Hrs. 8. Date of Birth onths Days Hours Min. May 1924 FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months 344-16-7183 82 Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Frederick Middletown Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be i 8709 N. Pacific Ct. 21769 is 23a must l USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after arent of Health and Mental Hygiene. And I fiem 27 is marked other than "natural", or ite any or other traumatte event, the Medical Examines my or other traumatte event, the Medical Examines 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) loan officer credit union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Murphy Margaret Lavelle ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or other trauonce. Margaret Seebald (Daughter) 8709 N. Pacific Ct., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 1/5/2007 Smithsburg, MD Other (Specify) 4 □ Donation 22 Name and Address of Facility Donald B. Thompson Funeral Home P. O. Box 18, Middletown, MD ie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final gastroesochageal Physician disease or condition resulting in death) /Medical ue to (or as a consequence of Examiner Monie obstructive cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Vear 4□Pregnant at time of death 5 Other (specify) been signed by the s 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ate has t autopsy certificate 2 No 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1. Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

P.O. Box 68760, Division or Vital Records, Attending Physician: ō Hospital

the

3altimore, Maryland 21215-0036

s after dea... ral Director: Aft filled in by within 24 hours a To the Funeral C

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number

BRUNSUTER KIS 2-1716

who completed cause of death (Item 23a) (Type, Print) Name and address of person

D0055061

29d. Date signed (Month, Day, Year) 5,2007

State Registrar

Medical

31. Date filed (Month. Day. Year! 0

rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Darrell Lee George Juratovac, Sr. 50 P M JANUARY 01 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore City 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 3, 1942 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Days Maryland 219-38-2868 64 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215-0036 MANO USA 21214 3206 Bayonne Avenue or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 2 If Yes, Give Year or Dates: Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation Medical 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Maker Cabinet Company 12 should be filed w h and Mental Hygie 7 is marked other t injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည George Juratovac <u>Katherine Hickman</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other tra Marline Ann Juratovac/wife 3206 Bayonne Avenue Baltimore, MD 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/03/07 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Bervice Ligense Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MEMORRHAGE disease or condition resulting in death) INTRACRANIAL /Medical Due to (or as a consequence of): **Examiner** MITRAL VALVE ENDOCARDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed SEPTICEMIA MRSA burial-tran and Due to (or as a consequence of) P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 GLEVATION MI MITRAZ 1 TYes 2□ No 3 Probably 4 □Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy SIP CORONARY certificate ARTER 1□ Yes 2ZNo Division or Vital 25. Was case referred to medical examiner?

1 Yes 2 No funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 □ Accident 5 Pending investigation r death. 1 ☐ Yes 2 ☐ No hours after death filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD RES 000

Registrar

DHMH 17 Rev 1/2001

State

GOOD SAMARITAN HOSPITAL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

APOORV BROOK

31. Date filed (Month, Day, Year)

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5601 LOCH

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day January 10, 2007 Medical Examiner 1110 hrs Ajay Kumar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 7132 Eden Brook Drive Columbia Howard 5 Social Security Number 6 Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or **Funeral** Davs Hours Director None 34 March 5, 1972 1 XM 2 F Country) India Usual Residence of Deceden 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Howard Columbia X Yes 2 23a or 28a-f shonotified at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7132 Eden Brook Drive 21046 India Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, "natural", or items the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 XMarried Armed Forces? White etc. Never Married Yes 2 X No f Yes, Give Year Divorced Yes 2 X No specify. Specify: Hindu ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 I and Mental Hygiene. marked other than MD 21215-0036 Chef Private 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Vishan Devi Kishan Lal event, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , vs Pages I and 2 sho nent of Health and aut: If item 27 is 2235 Westmoreland Street, Falls Church, VA 22046 Suras Kanojia (Brother-in-law) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 X Removal from State Important: 1/16/2007 New Delhi Crematory New Delhi, India Donation 5 Other Specify or ( Signature of Furieral Service Licer 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 art I. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Retween Onset and /Medical Death Diphenhydramine intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED #23a, 27, 28a-f physician a X UNPENDED 1/24/07 TT perME. g863. requires that the death certificate be Division of Vital Records, P.O. Box 68760, IE EEMALE 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? page ✓ Yes 2 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) æ Hospital: Other [ DOA Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes ို 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Yes 2 X No Pending subject ingested drug Fnd 1/10/2007 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be or Town, State) determined (Specify) To the Funeral Home 32 <u>Eden Brook Dr. Columbia.</u> Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. January 11, 2007 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 9, 2007 **Physician** 7:00 A.M Virginia Ruth Kelso /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Accident Cherry Hill Assisted Living Months Days Hours Min. June 3, 1923 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland 1 ☐ M 2 🔀 F Yrs 83 219-14-5281 Director Usual Residence of Decedent 10d, fnside City Limits 10c. City, Town or Location deeth with the Maryland 10b County 10a. State r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Accident Garrett Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21520 523 Negro Mountain Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No ff Yes, Give 11. Marital Status Black, White, etc. 72 hours efter 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 δ 3€3Widowed 4 □ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Depertment of Health end Mental Hygiene.
Important: If item 27 is marked other then "net any finjury or other traumatic avent, its Medical 2008. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma B. Ault Bruce Forsyth 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 585 Glendale Road, Oakland, MD June M. Harvey/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Luth. Cem | Jan 13, 2007 Accident, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Newman Funeral Homes, P.A., P.O. Box 275 21. Signature of Funeral Service Licensee Lynn 23a. Part 1. Enter the disease, or compfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD-Approximate Interval Between Onset and Death the roscleratio fmmediate Cause (Final cordiovosculor disease years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed the attending physicien and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) deteched 1 ☐ Yes 2 No P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate hes 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? assisted 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 🗌 Inpatient ၉ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: or Attanding 1 Natural 2 Accident 5 Pending investigation nours after death.

neral Director: After the function of the 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours at To the Funeral D completely filled is Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tele of certifier 00025759 ano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 247 Accident MD 21520 VUUMann W9 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Division or Vital Records, P.O. Box 68760 Physician: The law requires that the death certificate be

Vland 21215-0036

To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D21335 30. Name and address of person who come end cause of death (Item 23a) (Type, Print) Daniel J. Goldberg, M.D. 15225 Shady Grove Rd. #201 Rockville, MD 20850

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

Medical

JAN 0 4 2007



🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

		1	For State Registrar	State of Maryla	•		nt of H te of L		nd M		giene	007	013	354
Phys		n	. Decedent's Name (First, Middle, Las							2. Date of Dea Month Janual	Day	Year 2007		of Death
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Fune Direct	_			M 2□F 53	V	Months		Hours	Min.	(Month, Da) May 13	y, Year)	C	inois	
and		-	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation							10d. Inside	City Limits
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leath v		<u></u>	4211 Underwood S	12. Was Decedent Ever in	U.S. 13.		20740 edent of Hi		jin? (Spe	cify Yes or No- Rican, etc.)	US	14. Race - Ame		,
ite, Mal y idilia Z IZ 13-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Item 27 is marked other than "natural", or Items 23a or 28e-f ehow other reumatic event item 2000 or 28e-f ehow		2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		If Yes, spo 1 ☐ Yes		n, Mexican, Specify:	Puerto l	Rican, etc.)		Black, Whi	te, etc. Vhite	
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should be fill and Mental Him marked oth		Ö	Robert Luhr							ligan				
2 shou and N		-  -	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Addres	s (Street a	-			er, City o	r Town, State,	Zip Code)	
t and thealth em 27		-	Karen L. Presteg	aard - Spouse	. Place of Dispo	osition (Na	ame of			Unive:		y Park,		0782
Pages ent of nt: If it			1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre etropol	matory or	other place		1/3	/2007		xandria		rinia
Dermit. Pages 1 an Department of Heal Important: If item 2	ouce.		21. Signature of Funeral Service Licen		2	2. Name a	and Addres	s of Facility	1	me, P.A	7	739 Bal	timore	Ave.
3514	*		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de		A COLUMN TO THE PARTY OF THE PA		the color ball and other ball					Approxin Interval E Onset ar	nate Between
Physici /Medic	_		Immediate Cause (Final disease or condition resulting in death)	a Influenza									3 Day	
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w requires that the death been signed by the attershould be detached for us		٦	Part II, Other significant conditions o	ontributing to death but not	resulting in the u	ınderlying	cause give	en in Part I.			_	use contribute t No 3 □ P		
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o & 5 5		2	1 ☐ Yes 2 🛱 No 27. Manner of Death		ER/Outpatie			4 🗆 1901		ne 5 Resid		6 □Other (Spe	ecify)	
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DIVISION IN THE PARTY SERVICE SERVICE CONTRACTOR IN THE PARTY THE		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		reet, facto	ry, office		1	28f. Location (5 City or Tox		d Number or R	ural Route N	umber,
To the Hospitel or Attend within 24 hours efter death To the Funeral Director:	in the second	edicai		ysician: To the best of my l niner: On the basis of exam and manner stated.										e(s)
To ti	3		29b. Signature and title of certifier	7//		25	9c. License					te signed (Mon		r)
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- (/			30. Name and address of person who Mark Parkhurst,	MD 5711 Sai	rvis Ave		#200	), Riv	verda	ale, Ma	ryla	nd 2073	37	
Por	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnatur ;	ī					-			

07-00273 Joseph Lee Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Joseph Lee	1- For State Registrar		ent of Health and Men	, 0	eg. No. 200	0 0 1 3 5
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)  JOSEPH JI			2 Date of Deat Month January 10		3 Time of Death 0102 hrs
	4a. Facility Name (if not institution, give str Carroll Hospital Center		4b. City, Town, or Location of		4c. County of Death	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Year If Under	er 24Hrs. 8 Date of Birt	Carroll th(MM/DD/YYYY) 9 Birt	hplace (State or
Director	215-73-9566 1XM	2 F 1	Yrs. Months Days Hours		30, 2005 Foreig	n untry) MARYLAND
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
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the Maryland a or 28a-f sh tiffed at one Director	10e. Street and Number  1513 SEARCHLIGHT	T TIASZ	10f. Zip Code 21771	10	Og. Citizen of What Coun	try?
er death with t , or items 23a r must be not Funeral	11. Marital Status 12	. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	in? ( Specify Yes or No-	U.S.A.  14 Race - Americ White, etc.	an Indian, Black,
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MC sharth an m 27 i	EUN GU LEE - FATHER		1513 SEARCHLIGHT WAY of Disposition (Name of cemetery,	, MOUNT AIRY,		
불등등	1 Burial 2 X Cremation 3	Removal from State cremat	tory or other place)  NCOLN CREMATORY	1/11/2007	20c. Location - City or BRENTWOOD, MA	
Ports Ports ury 6	4 Donation 5 Other Specify: 21. Signature of Fun ral Ferrice Licensee		22. Name and Address of Facility HINES-RINALDI FU		,	IKILAND
m ad ≣ ≣ Physician	23a Part I Enter the disease, or complicate	ions that caused the death. Do no	11800 NEW HAMPSH	IRE AVENUE, SI	LVER SPRING, N	ARYLAND 20904 Approximate Interval
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3760, ficate be ex g physician s the burial	IF FEMALE. 23b. Was decedent pregnant in the	3c. If yes, outcome of pregnancy			23d Date of delivery	
). Box 687 the death certific by the attending p ched for use as the	past 12 months?  4 1 Yes 2 No 9 Unknown	Pregnant at time of death	Fetal death 3 Ectopic  Other (Specify)	pregnancy	Month D	ay Year
p.O. Bc that the der ned by the a detached fi			g in the underlying cause given in Pa	rt I. 23e. Did to	bacco use contribute to t	he cause of death?
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Vital Records, lysiciau: The law require. The law require this certificate has been significate, page 2 should be Gompleted				24a Was a autops perfori	sy prior to co	opsy findings available ompletion of cause of
al Re au: The rtificate tor, page			26 Place of Death (	1 Yes 2 Check only one)	No 1 Yes	s 2 No
f Vital Physician rr this certi ral director	1 ✓ Yes 2 No	I Inpatient 2 ER/O			Residence 6 Other	
on of Vending Phath ath or: After the funeral tion: T		28a. Date of Injury (Month, Day,Year)	Time of Injury 28c. Injury at Work	No 28d. Describe h	ow injury occurred	
Division of spital or Attending ours after death neral Director: Alfilled in by the fur Certification	2 Accident Investigation 3 Suicide 6 Could not be		arm, street, factory, office building, etc	28f. Location (S or Town, St	treet and Number or Run	al Route Number, City
D To the Hospital Within 24 hours To the Funeral completely filled		(Specify)  To the best of my knowledge, de.	ath occurred at the time, date and pla			d
To the Ho within 24 F To the Fun completely	one) 2 Medical Examiner; On		nvestigation, in my opinion, death occ		and place, and due to the	e cause(s)
2	29b. Signature and title of certifier $\mathcal{M}$ , $\mathcal{M}$	Cv	29c. License number  O.C.M.E.		January 10, 2007	
	30. Name and address of person who comp	4				
Cich	Ling Li, MD Assistant Medi	cal Examiner 111 Pen	n Street, Baltimore, MD 212	01		
State Registra		Stew St	Aprile			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Fix G864 2/05/07 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** G. Lilienfeld Month Year Eugene JANUARY 2007 /Medical 5:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE - POTOMAC POTOMAC MONTGOMERY **7** ial Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 x M 2 □ F 77 Yrs  $\frac{275}{275}$  - 24 - 8056 Director JULY 10, 1929 NEW YORK Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at MARYLAND MONTGOMERY POTOMAC Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9004 FALLS CHAPEL WAY 20854 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL LILIENFELD SARA BARKAN ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET LILIENFELD, WIFE 9004 FALLS CHAPEL WAY, POTOMAC, MARYLAND 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDEN OF REMEMBRANCE 01/03/2007 CLARKSBURG, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RECURRENT ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** MILTI ORGAN FAILURE Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed END STAGE PARKINSON'S DISEASE Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STEOARTHRITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 2X No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No Certification: To 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 Accident 2 🗆 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ID

DHMH 17 Rev 1/2001

State Registrar RAMAN R. TULI, MD, 10810 DARNESTOWN ROAD, SUITE 202, GAITHURSBURG, MD 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN

03

				State of Maryland / Department of Health and Certificate of Death	d Mental Hy	giene Reg. No	07	01357
		Physici		1. Decedent's Name (First, Middle, Last)  JORDEN LELAND LANGFORD	2. Date of D Month		Year C7	3. Time of Death
		/Medic Examir		4a. Facility Name (If not institution, give street and number)  Franklin Square Hospital Rosedale		4c. Cou	Inty of Death	ore
	100	- Funeral Director		5. Social Security Number    Sex   1 X M 2 G F   7. Age (In yrs! last birthday)   Yrs.   If Under 1 Year   If Under 24 H   Months   Days   Hours   Months   Age (In yrs! last birthday)   Yrs.   If Under 1 Year   If Under 24 H   Months   Days   Hours   Months   Age (In yrs! last birthday)   Yrs.   If Under 1 Year   If Under 24 H   Months   Days   Hours   Months   Days   Age (In yrs! last birthday)   If Under 1 Year   If Under 24 H   Months   Days   Hours   Months   Days   Days   Hours   Months   Days   Hours   Months   Days   Days   Hours   Months   Days   Days   Hours   Months   Days   Days   Days   Hours   Months   Days   D	in. (Month, D	irth (ay, Year)	9. Birth	place (State or Foreign intry) LAND
		death with the Maryland ms 23a or 28e-f show	Director	10a. State 10b. County 10c. City, Town or Location  MARYLAND HARFORD ABERDEEN  10e. Street and Number 10f. Zip Code		10g. Citizen	of What Cou	10d. Inside City Limits 1 1 1 No 2 □
الموادية	1215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-1 ehow or other treumatic event. Its Maxical Exactilise Livial by multies at	Completed by Funeral	482 EASTERN COURT  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes. Size No If Yes. Size Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes. Size No If Yes., Specify Cuban, Mexican, Pu 1 ☐ Yes. 2 ☐ No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of with Do NoT use retired)  NEVER WORKED		14. F	ISA Race - Amer Black, White cify: BLAC NAT f Business/li	, etc. CK IVE AMERICAN
Babo	land 2	uld be filed v fental Hygie rked other i tic event, th	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's N	Name (First, Middle E JE-NEA		,	
Merris,	Baltimore, Maryland 2121	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny in ury or other treumatic once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  LISA SCOTT FUNI	BERDEEN, Date /16/07 ERAL HOMI	MARYLA 20c. Location HAVRE	ND 210 on - City or T DE GRA	001 Town, State ACE, MD
Ø	8760,	bhysician and hysician and hysician and hysician and hysician and the buriat-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause of the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  552 LEWIS STREI  552 LEWIS STREI  A Cause (Final death). Do not enter the mode of dying, such as card shock or each line.  Premature delivity  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.	ET, HAVRI	E DE GR	ACE, N	Approximate Interval Between Onset and Death
gtord	.d. Box 6	es that the death certific igned by the ettending p be detached for use es	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			Date of deliv Month	very Day Year
Lan	Records, P.	law requires that as been signed b 2 should be deta	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 = 24a. Wa	Yes 2/10	3 ☐ Pro	the cause of death? bably 4 [Unknown opsy findings available ompletion of cause of
Jorden	Division of Vital Re	or Attanding Physician: ther death. Director: After this certifica in by the funeral director, I	Certification: To Be Com	25. Was case referred to medical examiner?  1   Yes   2   No	period 1   Yes   Death   Check only   G Home   5   Res     28d. Describe     28f. Location	one) sidence 6 0	death? 1  Yes Other (Speci	2 🗆 No
		To the Hospital within 24 hours a Youth Completely filled	Medical C	29a. Certifier (Check only one)  Control in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred and manner stated.	tee, and due to the courred at the time	cause(s) and , date and place	manner as t	stated. to the cause(s)
		To # with To # comp	2	29b. Signature and titleyof centrier  Conton  D00639	66		10/2	w7
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Adiarn Goitom, 9000 Franklin Square Drive  31. Date filed (Month, Day, Year) 32. Registrar's Signature.	, Balti	more.	mj	21237
		Sta Regist		31. Date filed (Month, Day, Year) AN 1-6 2007 32. Registrar's Signature				

			1 - For State Registrar		aryland / Depa <i>Ce</i>	artmen rtificate				R	eg. Na	007	013	58	
	Physici	ian	Decedent's Name (First, Middle, Last	•					İ	<ol><li>Date of Deat Month</li></ol>	Day	Yeer	3. Time of [		
	/Medi		Harry Clarkson Lav			1				January					
	Examir	ner	4a. Facility Name (If not institution, give Catered Living of		0.5			Location	of Death			ounty of Death			
			5. Social Security Number 6. S		e (In yrs. last birthday)	Ocea:		If Under	24 Hrs.	8 Date of Birth		orcester	r lace (State or	Foreign	
М	Funeral Director			⊠M 2□F	93 Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day, March 2	Year)	3 Mary	trv)	roroign	
			Usual Residence of Decedent			11						J J			
	how		10a. State 10b. County		10c. City, Town or Lo	ocation						1	0d. Inside City		
	Ba-fs	cto	Maryland Worcest	er	Ocean	Pine	S						1 🗆 Yes	255 No	
	72 hours after death with the Maryland natural; or Items 23s or 28s-f show disal Examiner must be notified at	Director	10e. Street and Number			10f. Zip				1	0g. Citize	en of What Coun	try?		
	ath w	ral	1135 Ocean Parkway				218					ted Stat			
	er de Item	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Deced	ent of H	ispanic Ori n, Mexicar	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14	<ol> <li>Race - Americ Black, White.</li> </ol>			
36	s after	by F	1 ☐ Never Married 2 ☐ Married  3 ₹XWidowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1 🗆 Yes 🔞	No Section	Specify:	:		s	Specify: W	nite		
21215-0036	hour	edt	15. Decedent's Ed		16a Dece	dent's Usua	I Occurs	ation			16h Kind	d of Business/Inc	tustn/		
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212	within jiene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or !		trepr	eneu	r			]	Dry Clea	ning		
	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle, I					
lar	Mental I Merked of atto eve	To E	Gabriel Lawson					Ste	ella N	Mae Holi	land				
Maryland	2 should and Men Is marke sumatic		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address	(Street a	and Numbe	er or Rural	Route Number	City or	Town, State, Zip	Code)		
	and 2 aalth n 27 l		Harry T. Lawson /	Son	702	Wynga	te I	r.,	Frede	rick, M	D 21	702			
ore	of He if iter		20a. Method of Disposition 1 total 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemeters, cre Res	osition (Nan	ne of ther plac	θ)	Jan.	ete 6,	20c. Loca	ation - City or To	wn, State		
Ë	Pag ment ant: jury		*4 □Donation 5 □ Other (Specific		Memorial	Gard	ens		2007			erick,		nd	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fundal Service Lice	500	Ŕ	2. Name an esthav	d Addres	s of Facili Funer	al Se	ervics,	Skko	ot Cody	P.A.		
_	40 = # a	-			19.	501_Ca	itoc	tin_M	ltn.l	lwy. Fre	ederi	ick, MD	21701		
THE REAL PROPERTY.	Physician /Medical Examiner	er	shock of beart failure List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or as,	a consequence of):	s. Pu	J.	Dis	· iless	Tospilatory and	,		Approximate Interval Betw Onset and De	neev	
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	icai Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):				P-1-4500						
P.O. Box 6	that the death certificated by the attending photograph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic pr ⊒ Other (sp					23	d. Date of delive Month	,	ear	
Records, P	w requires that been signed I should be det	à	Other significant conditions of the Control of the	ontributing to death b	ut not resulting in the u	inderlying ca	ause give	en in Part I	l.		acco use	e contribute to th		ath? nknown	
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Ä	The law	E								autops perform	ned?	death?	npletion of cal 2□4No	usa oi	
Vital		0	25. Was case referred to medical					26. Place	e of Death	(Check only on		1 1 100			
>	Physician: this certificaral director, p	To B	examiner? 1 Tes 2 No	Hospital: 1   Inpatie	ent 2 ER/Outpatier	nt 3 🗆 DO	A Othe	9r: 4 🗆 Nu	ursing Hom	ne 5 🗆 Reside	nce 67	Sother (Specify	ASSI	Sal 1	
n of	ding Physician: h. After this certifical funeral director.		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	ry y Year) 28b. Time o	of 2	Bc. Injun	at		8d. Describe ho			LIVIN	Ġ.	
Sio	Attending in death.	cati	2 Accident investigation			М	1 🗆 '	Yes 2							
Division	in the	Certification:	4 Homicide determined	building, et	ury - At home, farm, st c. (Specify)				Į	City or Town	, State)	Number or Rura		er,	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a, Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best niner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred avestigation,	at the tim in my op	ne, date an pinion, dea	nd place, a ath occurre	nd due to the ca	ause(s) a ate and p	nd manner as sta lace, and due to	ated. the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier	2				number				signed (Month, L			
,			1 0	ND		n	112	Dac	634	24 ८	Ja.	1. 05	200	7	
_	Q		30. Name and address of person who	ack Rd	leath (Item 23a) (Type	Print)	19	318	11 -,	ma	1116	n. 05.	mD		
	Sta		31. Date filed (Month, Day, Year)	107 32. Pegistr	ar's Signature	costs	9								

			For State Registrar	State of M	laryland	-	artment of He rtificate of D		Mental H	ygiene	07	01359
era.	Physici	ion	1. Decedent's Name (First, Middle, L	ast)					2. Date of D		Vear	3. Time of Death
	Physici /Medi		PAULINE LOUIS	E LENHART	1				JÄNUA	$RY \stackrel{Day}{4}$ , 20	00 <sup>Year</sup>	8:40A M
3	Examir	ner										
meter		4	FREDERICK MEMOR				FREDERICK				DERICE	K
Ė	Funeral Director		5. Social Security Number 6. 219-12-1802	Sex 7. A 1 M 2 XF	age (In yrs. Ia 83	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, L	irth Day, Year) <b>7.1923</b>	Cou	place (State or Foreign Intry) y land
	pu »	1	Usual Residence of Decedent  10a. State 10b. County		100 City	Town or Le	antian					
	aryta shov	=			Too. City	, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 [XNo
	he M 28a-f otifie	Director		erick			Frederic	k				
	a or be n	ä	10e. Street and Number				10f. Zip Code			10g. Citizen of		•
	eath	eral	7712 McKaig Rd.	12. Was Deceden	t Ever in II S	10		21701	Cnecify Vec on h	14 Ps	U.S.A	· ·
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces  1  Yes 2 Yes  If Yes, Give  Year or Dates	;? ¶No		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No	, Mexican, Puer Specify:	rto Rican, etc.)		ack, White,	, etc.
5-0036	2 hou	ed	15. Decedent's E		Ĭ	16a. Dece	dent's Usual Occupat	ion		16b. Kind of I		
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2121	d with	Completed	10	Conege (1-40)	3+7		seamstres	S		cloth	ing f	factory
pu	al Hy other vent,	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Na	me (First, Middl	e, Maiden Surna	me)	
/lai	Ment Ment arked	ဦ	Amos Abner Smit	h				Kati	e Pauli	ne Sappi	ngtor	า
Maryland	2 sho and is mi		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street ar	nd Number or R	Rural Route Num	ber, City or Town	ı, State, Zij	p Code)
	and lealth m 27 her tr		Pauline E. Tipto	n/ daughte			tewart Dr	. Sis		le, WV 2		
ore	ges 1 f of H if ite		20a. Method of Disposition  1 Burial 2 □ Cremation 3	☐Removal from State	e ce	emetery, crei	sition (Name of matory or other place	•	Date	20c. Location	- City or To	own, State
Ë	trmen tant: jury		4 □ Donation 5 □ Other (Spec	ify)	Rest		Mem.Gard		/2007	Freder	ick,	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		21. Signature of Funeral Service Lice	). Lan 12	ler	- 1	2. Name and Address 1802 Libe	П		Funeral		
	*1190		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that	ed the death.						_110 2	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			.0.22	2					Onset and Death
	/Medical		resulting in death)		s a conseque		awas La	PROMIA				1-2 WEEKS
	Examiner		Sequentially list conditions	b								
	7 ±	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or a	s a consequi	ence of):						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
50,	cian a	<u> </u>	rooding in doday, Edot	Due to (or a	s a conseque	ence of):						
68760,	eath certificate be executed aftending physician and for use as the burial-transit	edical		_d								
9 ×	ding page as	/Me	IF FEMALE:	23c. If yes, outcom	o of oromoon	201				7.0		
Вох	The law requires that the death certi ate has been signed by the attending age 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live birth	2 Fetal	death 3□	Ectopic pregnancy Other (specify)				ate of delive onth	ery Day Year
P.0.	res that the de signed by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	at time of de	atri 5L	Joiner (specify)					
σ.	that led by deta	4 h	Part II. Other significant conditions	contributing to death	but not resul	ting in the u	nderlying cause given	in Part I.	23e. Did	tobacco use cor	tribute to t	he cause of death?
Vital Records,	quires n sigr ald be	d by	PERICARD	INC EFFL	ره				1	Yes 2⊒1√No	3 Prol	bably 4 Unknown
00	w requir s been s should	lete						<del>-</del>	24a. Wa	s an 24h	Were auto	opsy findings available
Re	The lay	Completed							auto peri	opsy formed?	prior to co death?	empletion of cause of
ta	ilcian; Th certificate ector, pag	Be C	25. Was case referred to medical				-	26 Place of De	ath (Check only	2 No	1 ☐ Yes	2∐ No
>	ysici is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ Ho	Hospital:	ient 2 ☐ E	R/Outpatien	t 3 DOA Other			sidence 6 □Ot	her (Specia	6/)
٥٢ ا	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury (	28b. Time of Injury	28c. Injury a Work?			how injury occu		
Ö	endir ath. or: Af	atio	2 ☐ Accident investigation	n	uy . ou/	11,141,7		es 2∐No				
Division	or Att ter de ilrect	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	20e. Place of it	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. Location City or To	(Street and Num own, State)	ber or Rura	al Route Number,
	pital ( urs af eral D		00 0 17									
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 CertifyIng P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manuers	of examination	rledge, death on and/or in	n occurred at the time vestigation, in my opi	, date and plac nion, death occ	e, and due to the curred at the time	e cause(s) and π e, date and place	anner as s , and due t	stated. o the cause(s)
	To t Withi To t	Σ	29b. Signature and title of pertifier				29c. License r			29d. Date signe	ed (Month,	Day, Year)
	- l		<b>•</b>	M.	MD		D	32171		1	4/0	7
	nr		30. Name and address of person who									
	9			L. GoyGH	P	0 130	x 328	WALKER	ESUILLE	MD	217	43
	Sta Registr		JAN 0 5 20	07 Septem	trars Signati	Jos	x 328					

			_ State	te of Marylan		rtment of H			211	07 01360	
Е	- 8	-	Registrar  1. Decedent's Name (First, Middle, Last)		061	incate of L	Jean	2. Date of Deat	h	3. Time of Death	
	Physicia /Medic	_	Francis AKA Frank	Theodore	Langway	Jr.		January 1	L, <sup>D</sup> 2007	6:00 P M	
	Examin		4a. Facility Name (If not institution, give street a 8426 Thomberry Drive Ea	nd number) ast		4b. City, Town, or Upper Mar		th	4c. County o	f Death ce George's	
	Funeral		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs.		If Under 1 Year Months Days				9. Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent					NOV . 27 ,	1937	Massachusetts	
o propor	tat		10a. State 10b. County		y, Town or Lo					10d. Inside City Limits	
Mod	8a-f s	Director	Maryland Prince George	s Up	per Mar	1			0.000	1 □Yes 2 No	
t t	a or t	D	10e. Street and Number 8426 Thornberry Drive	ast		10f. Zip Code 20772		"	ng. Citizen of Wh USA	nat Country?	
doop	ms 23	Funeral	11 Marital Status 12. Wa	s Decedent Ever in U	.S. 13. y		spanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race	- American Indian,	
d 21215-0036 fled within 72 hours ofter death with the Manufand	Health and Mental Hygiene. The matural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 120	Yes 2□ No 1956 es, Give	<u>.                                    </u>	☐ Yes <b>X</b> No	Specify:	no nican, etc.)	Specify:	White, etc. White	
Baltimore, Maryland 21215-0036	atural	ed b	3 ☐ Widowed 4 ☐ Divorced Yes	r or Dates: 1960	16a. Deced	ent's Usual Occupa	ation	- 1	16b. Kind of Bus		
לול הלול	an "ne Medik	Completed	(Specify only highest grade comp	leted) lege (1-4or 5+)	1	kind of work done of OO NOT use retired	luring most of wo )	orking			
213	ygien ygien t, the	Con	6		Insu	rance Agent			Insuranc		
and	and Mental Hygie	Be	17. Father's Name (First, Middle, Last) Francis Theodore Langu	vay Sr.				me (First, Middle, M Jane McClo		)	
arylan shauld be	nd Me mark umatic	은	19a. Informant's Name/Relationship (Type. Prin		19b. Mailin	g Address (Street &	and Number or F	Rural Route Number	City or Town, S	tate, Zip Code)	
;, Mg	alth a		Kathryn R. Langway / Wit					East Upper	Marlboro	, Maryland 20772	
ore	0		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Remova	from State	Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Location - C	City or Town, State	
	Department Important: I any Injury o	Ц	4 □ Donation 5 □ Other (Specify)  21. Signature of Aneral Service Licensee			on Cemetery . Name and Addres		5/2007 (	Clinton, M	faryland	
Ba	Depa Impo any I		21. Signature of purietal service Licensee		- 6	5160 Oxon H	Ge ill Road (	eorge P. Ka Oxon Hill, N	las Funera	1. Home PA 20745	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the deat e on each line.						Approximate Interval Between	
	hysician		Immediate Cause (Final disease or condition		1 Cell	Lung Can	cer			Onset and Death 5 years	
	/Medical xaminer		resulting in death)  Due to (or as a consequence of):								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury	uence of):							
of the	nd transit	Examiner	that initiated events C.								
Records, P.O. Box 68760,	ohysician and the burial-transit	al EX	resulting in death) Last	ue to (or as a conseq	uence of):						
687	physis the	edical	d								
Box	attending p	M/ne	23b. was decedent pregnant	es, outcome pf pregna Live birth 2 🗆 Feta		Ectopic pregnancy			23d. Date		
Э. В	the att	Physician/Me	1 Ves 2 No	Pregnant at time of d		Other (specify)			Mont	th Day Year	
ج ق	igned by the a		Part II. Other significant conditions contributing	g to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?	
rds	n sign	ed by						1 □ Y€	es 2∐No 3	B□ Probably 4√3Unknown	
Vital Records, P.O	has been si ge 2 should t	Completed						24a. Was a		ere autopsy findings available ior to completion of cause of	
		Com						perform 1 Yes 2	ned? de 1∐No 1[	ath? ☐Yes 2☐ No	
	certifi	Be	25. Was case referred to medical examiner?		1500.4	t 3 DOA Othe	\r'	eath (Check only on			
vision or Vita	After this funeral di	7: To	27. Manner of Death 28a	Date of Injury	ER/Outpatien 28b. Time of	· OLI BOX	4 LI Nursing	Home XX Reside			
Sion	leath. tor: After the funer	atio	1X Natural 5 Pending investigation	(Month, Day Year)	Injury		Yes 2 □ No				
	after death  Director: in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e	Place of injury - At he building, etc. (Specif	ome, farm, stre fy)	eet, factory, office		28f. Location (St. City or Town	reet and Number , State)	r or Rural Route Number,	
Div	within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier Certifying Physician:	To the best of my kno	owledge, death	occurred at the tin	ne, date and place	e, and due to the ca	ause(s) and man	ner as stated.	
1	in 24 l	edical	A	n the basis of examina d manner stated.	ation and/or in					` ` `	
F	within 2  To the comple	Σ	29b. Signature and title of certifler	1		29c. License		[	9d. Date signed January 2	(Month, Day, Year)	
7	(6)		30. Name and address of person who complete	d cause of death (Item	n 23a) (Type						
K	(8)			00 Reservoir	Road I	W Washing	ton. DC 2	20007			
			b oom beatan in a	32. Registrar's Signa							

Registrar DHMH 17 Rev 1/2001

		1	For State Registrer	State of	Maryland				lealth a Death	and M		giene Reg. No	2 H H J	1 (	01361
H			1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath Day	y Year		I. Time of Death
	Physicia /Medic	al	Alan E. Martz								1	4	2007		2240 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution	, give street and num	ber)		4b. City	Town, or	Location of	of Death		4c.	County of De	ath	
			Peninsula Regio		al Cente			lisb r 1 Year		24 Hrs.	8. Date of Birt		Vicomic		e (State or Foreign
	Funeral Director		214-34-9931	1 X M 2 ☐ F	69	Yrs.	Months		Hours	Min.	(Month, Da 6 22	y, Year)	37	MD	i claid of t oragin
			Usual Residence of Decedent					l							
	yland		10a. State 10b. County		10c. City, T	own or L	ocation								Inside City Limits
	• Mar	ctor	MD Wicon	nico	Pit	tsvi	11e								1 ☐ Yes 2/€∑rNo
	ath with the Marylan 23a or 28e-f ehow ust be notified at	Directo	10e. Street and Number				10f. Zi	Code				10g. Cit	izen of What (	Country'	?
	ath w	ral	35805 Six Chix					850			-7 V N-		J <u>SA</u> 14. Race - An		Indian
	er de Itame	Funeral	11. Marital Status	Armed For	dent Ever in U.S. ces?		If Yes, spe	dent of H	ıspanıc Ori ın, Mexicar	gin? (Spe n, Puerto l	ecify Yes or No Rican, etc.)	-	Black, Wi	nite, etc.	
36	rs aft	by F	1 ☐ Never Married 2X Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	<sup>2□No</sup> Navy		1 🗆 Yes	2 <b>⊠</b> No	Specify:				Specify: Wh	ite	
Maryland 21215-0036	tiled within 72 hours after death with the Maryland Hygiene. other than Insturel; or Itame 23a or 28e-f ehow ent, the Madical Examinar must be notified at		15. Deceden		1	16a. Dece	dent's Usu	al Occup	ation	A - 6 de:		16b. K	ind of Busines		
212	nin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	ise retired	during mos d)	t or workii	ng				
2	giene giene er th	P O	8th			In	stall	er					sulatio	n	
-	m - 0 5	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	, <i>Maid</i> en	Sumame)		
<u>X</u>	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other then "naturel", or Itame aumatic event, the Madical Examinar m	၉	Unknown							су К			. T	7:- 0-	-d-1
ă	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 Is marked any injury or other traumatic es	1	19a. Informant's Name/Relations		i						I Route Numbe				000)
e,	1 and Health em 2 ther 1	1	Norma Jean Mart 20a. Method of Disposition	z (wile)	20b. Plac		osition (Na ematory or				ittsvil Date		MD ZI8		, State
פַֿ	ages nt of l		1 Burial 2 ☐ Cremation		state		<sub>matory`or</sub> de Ce			1/0/	2007	Pos	alim N	(I)	
altimore,	ntme ortant injury	1	4 Donation 5 Other (S		A						e Burba		clin, M		m.o.
Ba	permi Depa Impo any ir										rlin, M			. по	iiie
			23a Part 1. Enter the disease of	complications that ca	aused the death.									A	oproximate terval Between
	Physician		shock, or heart failure List Immediate Cause (Final		SCVD		Δ	SCV	de						nset and Death
de.	/Medical		disease or condition resulting in death)	a	or as a consequer	nce of):		1200	No.		·				
	Examiner		Conventigible list conditions	b											
	שָּׁה מ	ne	Sequentially list conditions, it any leading to immediate cause. Enter Underlying	Due to (	or as a consequer	nce of):									
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (	or as a conseque	naa of):								-	
8760,	ate be executed only sicien and the burial-transit	Ē	Tooling in doain, and	508 10 (1	or as a consequer	100 01).									
	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dicai		d											
9 X	that the death certifics ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnanc		_						23d. Date of o	delivery	
Вох	death atter	ciar	in the past 12 months?	4□Pregn	irth 2∏Fetal de ant at time of deal		□Ectopic   □ Other (s		/				Month	Da	ıy Year
<u>о</u> .	t the c by the achec	hys	9 Unknown	9□ Unkno	)W/I						- 8657				
	res thai signed t	by P	Part II. Dther significant conditi		ath but not resulti	ing in the	underlying	cause giv	en in Part	l.					cause of death?
Ĕ	w require been sig should b		Cardiomyopat	hy					<del></del>		1 🗆	Yes 2	<b>⊠</b> No 3□	Probab	iy 4 ∏Unknown
၁၁	e law requ has been je 2 shouk	piet	DM								24a. Was		24b. Were	autopsy o comp	findings available letion of cause of
Ě	The ete h page	Completed									perfo 1 ☐ Yes	ormed?	death	? es 2[	
ita	ician: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?					i a		e of Deatl	h (Check only	one)			
× ×	Physic this or al dire	မ	1 <b>X</b> ∕es 2 No			-VOutpatie		UA			me 5 ☐ Resi			ресіту)	
ŭ	ding P. h. After I	on	27. Manner of Death 1 ☐Natural 5 ☐ Pendi	19	th, Day Year)	8b. Time Injury	of M	28c. Injui Wor	ryat rk? ∣Yes 2.⊡	1	28d. Describe	now inju	ry occurred		
Sic	Attending Physician: r death. ector: After this certific by the funeral director.	icat	3 Suicide 6 Could		of Injury - At hom	e farm s			103 2		28f. Location (	Street a	nd Number or	Rural R	Route Number,
Division of Vital Records,	or A after Direction by	Certification:	4 Homicide determ		ng, etc. (Specify)	o, iaiii, s	croot, racto	ry, omoo			City or To				,
	spital ours nerel filled	a C	29a. Certifier 1 X Certifyi	ng Physician: To the	best of my knowl	edge, dea	th occurre	d at the ti	me, date ar	nd place,	and due to the	cause(s	and manner	as state	∍d.
	P 24 P	edicai	(Check only 2 Medical one)	Exeminer: On the ba	asis of examinatio ner stated.	n and/or i	nvestigatio	n, in my o	opinion, dea	ath occur	red at the time,	, date an	d place, and c	lue to th	ie cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certific	er			2	c. Licens	se number			29d. Da	ate signed (Mo	onth, Da	y, Year)
	_		1 ( She	( bu				HJ	044	/		1/	7/0/		
			30. Name and address of person	who completed caus	e of death (Item 2	3a) (Type	Print)	L1		<.	11	- /	v 21	061	
	BASH		Chris Snyd	er vo.	100 E	Ca	roll	17	•	بلار	11) buy	~	2	w)	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year	2007	legistrar's Signatu	K K	mode	,							

07-00002		Please Type or Print in Black Inde			jible.						
Antonio Matthew		I- For State Certific	ment of Health and Me cate of Death	lygiene Re	2007	0136					
Physicia Medical Exami		Decedent's Name (First, Middle,Last)		Date of Death     Month	Day Year	3 Time of Death 0225 hrs					
Medical Exami		ANTONIO MATTHEWS  4a Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	January 1,	4c. County of Death	0220 1113					
		Prince George's Hospital Center	Cheverly		Prince George'						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Months Days Hours Mil	1	h (MM/DD/YYYY) 9 Birth Foreign	place (State or VASHINGTON htry)					
		578-06-2226 1 M 2 F 25  Usual Residence of Decedent	Yrs.	12-25-	1981   6601	DC DC					
w any			vn or Location			10d Inside City Limits					
ryland a-f sho	ctor	DC WASHI  10e Street and Number	NGTON 10f Zip Code	110	g. Citizen of What Count	1 Yes 2 No					
15-0036 filed within 72 hours after death with the Maryland Hygiene d other than "natural", or items 23a or 28a-f show i, the Medical Examiner must be notified at once.	Director	5234 4th STREET NE #201	20011		.,						
h with ems 23.	Funeral	11. Marital Status 1. Was Decedent Ever in U.S 1. V Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puert		14. Race - America White, etc	an Indian, Black,					
er deat		1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	o , tiodii, 0.0.,		LACK					
ours aft	d by	Lor Dates.	a. Decedent's Usual Occupation (Give kind of		dustry						
36 n 72 hc ian "nz	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) $12\mathrm{th}$	during most of working life. DO NOT use re MAIL CLERK	tired)	PRIVATE						
5-0036 led within 7 Hygiene other than	mo	17. Father's Name (First, Middle, Last)		e (First, Middle, M							
215 be file ntal Hy rked o	Be	JEFFREY ALLEN REEVES	EE BONEY	·							
D 21 should be and Mer 7 is mar	٢		19b. Mailing Address (Street and Number or $12597$ ASHGLEN DR NOR								
Baltimore, MD 21215-0036  pernit Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items: injury or other traumatic event, the Medical Examiner must be.		20a. Method of Disposition 20b. Plac	e of Disposition (Name of cemetery,	Date	20c. Location - City or T						
Baltimore, permit Pages I an Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State RIVER		-06-07	RIVERDALE,						
Salti ermit epartm mporta njury o	l û	21. Signature of Funeral Service Licensee	22. Name and Address of Facility JB 7474 LANDOVER RD	JENKINS	MD 20785	fΕ					
Physician		23a. Part I. Enter the disease or complications that caused the death. Do				Approximate Interval					
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a, Multiple Gunshot Wounds										
LAGITITIES		or condition resulting in death)  Due to (or as a consequence of)									
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	Examine	cause. Enter Underlying Cause (clustease or impury that initiated events resulting in death). Last	<u> </u>	-							
executed an and al - transit	cal E)										
9 E E	ledic	UNPENDED AMENDED									
Box 68760, death certificate be extending physician ed for use as the burial.	Physician/Medi	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth	cy 2 Fetal death 3 Ectopic pregr	ancy	23d Date of delivery  Month Da	ay Year					
Sox death of attender for use	ysici	Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)		1	1)					
S, P.O. Be Lires that the de a signed by the detached for		Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.		bacco use contribute to th						
S, P, Luires th unives the signe an signe at the de	ed by			1	2 No 3 Proba						
tal Records, trian: The law requirectificate has been sector, page 2 should	Completed			24a Was a autops perfor	sy prior to co	opsy findings available impletion of cause of					
Rec: The liftcate liftcate l		25. Was case referred to medical	26 Place of Death (Check	1 Yes 2		2 No					
Vital ysician:	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER	Othor		Residence 6 Other	<del></del>					
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	$\vdash$	27. Manner of Death 28a Date of Injury 28i	b Time of Injury 28c Injury at Work?	28d Describe h	ow injury occurred						
Division spiral or Attend cours after death, reral Director:	Certification:	2 Accident Investigation Jan 1, 2007 01	JUND: 1 Yes 2 ✓ No 36 hrs , farm, street, factory, office building, etc.		treet and Number or Rura	ol Pouto Number City					
Divi	ertifi	3 Suicide 6 Could not be determined (Specify) Emergency R		or Town, St							
D: Hospital 24 hours 5 Funeral etely fillec		29a Certifier 1 Certifying Physician: To the best of my knowledge, a	death occurred at the time, date and place, an								
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/o and manner stated									
	2	29b Signature and title of certifier	29d Date signed (Month, Day, Year) O.C.M.E. January 1, 2007								
		30. Name and address of person who completed cause of death (Item 23a	-								
12 (4)	F 13		1 Penn Street, Baltimore, MD 212	01							
Si Regis	tate trar	31. Date filed (Month, Day Year)  AN 0 4 2007  Sansur J.	de								
Regis	GIQ.	Unit U									

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 363 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 5, Hannah Ellen Isabel Mothershead January 2007 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Ravenwood Lutheran Village Hagerstown Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2 💢 F 1914 Maryland 577**-**05-9<u>794</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1183 Luther Drive 21740 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White 3 Midowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Beauty Shop Receptionist/Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname)

Rosalie Tucker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

415 E. Wilson Blvd. Hagerstown, Md. 21740

20c. Location - City or Town, State

Lantana, Florida

Minnich Funeral Home

Street Heigestern MD 21740.

17922 Garden Lane #32 Hagerstown, Md. 21740

**Physician** /Medica Examine

**Physician** 

/Medical

**Examiner** 

10a. State

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Henry Esau Buckmaster

Robert E. Mothershead - Son

1 ☐ Burial 2 ☐ Cremation 3 X Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN 2 AR. 2 S HAH 368 NUL

31. Date filed (Month, Day, Year)

32. Registrar's Signature

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or edical Examiner must be

tal Hygiene. d other than "natura event, the Medical E

alth and Mental Hygi 27 is marked other r traumatic event, t

Department of Health a Important: If item 27 is any injury or other tra once.

**Funeral Director** 

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Completed

Be

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition		allow acribe		Interval Between Onset and Death
	resulting in death)	Due to (or as a consequence of):	production of the second	101	
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b			
sal Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		etopic pregnancy ther (specify)	2	3d. Date of delivery Month Day Year
	Part II. Other significant conditions of	ontributing to death but not resulting in the unde	rlying cause given in Part I.		se contribute to the cause of death?  No 3 □ Probably 4 ☑Unknown
Completed by				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
BeC	25. Was case referred to medical examiner?	14 =	26. Place of Death	(Check only one)	
70 E	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 ☐ Residence 6	3 ☐Other (Specify)
	27. Manner of Death  ↑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Street and City or Town, State,	d Number or Rural Route Number,
Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my knowledge, death o niner: On the basis of examination and/or investand manner stated.	ccurred at the time, date and place, stigation, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)
Me	29b. Signature and title of certifier		29c. License number	29d. Dat	e signed (Month, Day, Year)
	Maujen.	tollap	D28365		1/8/07

20b. Place of Disposition (Name of cemetery, crematory or other place)

Palm Beach Mem. Park 1/10/07

22. Name and Address of Facility

State Registrar

5H-1

07-002ปี3 Patricia Daniels Moore

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1-For State Certificate of Death	J	. No. 200	1 01361
Physicia Vledical Exami	ın/		2. Date of Death Month I January 7, 2	Day Year	3 Time of Death 3
nourour Exami		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	January 7, 2	4c. County of Death	
		13515 Holly Lane Ocean City  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I ff Under 24Hrs.	O Date of Digital	Worcester (MM/DD/YYYY) 9 Birt	hplace (State or
Funeral Director		170-58-4604 1 M 2 X F 44 Yrs Months Days Hours Min.	04/05/1	Egrala	
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
aryland Sa-f show at once.	٥	MD WORCESTER OCEAN CITY			1 X Yes 2 No
0036 within 72 hours after death with the Maryland jeine ner than "natural", or items 23a or 28a-f show any Medical Examiner must be notified at once.	Director	10e. Street and Number       10f. Zip Code         13515 HOLLY LANE       21842	Ţ	Citizen of What Cour JSA	try?
ath witl items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3. Was Decedent of Hispanic Origin? (Sp. Armed Forces? If Yes, specify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14 Race - Ameri White, etc.	can Indian, Black,
after de al", or	by Fu	1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, give Year or Dates		Specify: WH	ITE
hours a	ed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a Decedent's Usual Occupation (Give kind of w during most of working life DO NOT use retired to the content of the		16b. Kind of Business/I	ndustry
5-0036 led within 72 hours tygiene other than "natur the Medical Exami	Completed	1 TEACHER		EDUCATION	
21215-0036 hould be filed within 77 and Mental Hygiene is marked other than rite event, the Medical	Be Cor	17. Father's Name (First, Middle, Last)  WILLIAM JAMES DANIELS  18. Mother's Name  JOAN W		aiden Surname)	
MD 21215-0036 nd 2 should be filed within 7 ath and Mental Hygiene m 27 is marked other than aumaric event, the Medica	2	19a. Informant's Name/Relationship (Type, Print)  NATHAN DANIELS/SON  19b. Mailing Address (Street and Number or R 34341 VAN DYKE ROAD,	GOLTS, N	er, City or Town, State. ID 21635	Zip Code)
ore tr		20a Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify.  20b. Place of Disposition (Name of cemetery, crematory or other place)  CHESAPEAKE CREMATORY 01/	i	20c. Location - City or STEVENSVIL	
Baltimo permit. Page Department of Important: injury or otd	Ī	21 Signature of Funeral Service Licensee 22 Name and Address of Facility	N AND NE	EWNAM FUNER	AL HOME, PA
Physician	-	Arick of Stelfenlein FELLOWS, HELFENBEI 130 SPEER ROAD, CH 23a Part I. Enter the disease, or compiler ons that caused the death. Do not enter the mode of dying, such as cardiac or	ESTERTOV respiratory arres	VN MD 2162 st, shock, or heart	Approximate Interval
/Medical Examiner	i	failure. List only one cause on each line.  Immediate Cause (Final disease a. Cardiac arrhyrhmia			Between Onset and Death
Manager and to go		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  Neurocardi venic sick sinus syndrome			
	ner	if any, leading to immediate Due to (or as a consequence of):			
it i	Examiner	(Disease or injury that initiated events resulting in death) Last			19
xecuted n and l - trans		d.  X UNPENDED AMENDED DIT 27 ME OCA 2 (0/07 FFF			
760, icate be executed physician and the burial - transit	Medical	IF FEMALE: 123c. If yes outcome of pregnancy		23d Date of delivery	
ox 68760, sath certificate be attending physic or use as the but		23b Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant	псу	1	ay Year
Box death control death contro	Physician	1 Yes 2 No 9 V Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
that the d	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		acco use contribute to t	
of Vital Records, P. ing Physician: The Jaw requires the Arther this certificate has been signed inected, page 2 should be d.	ted k	Seizure disorder	1 Yes	2 No 3 Prob	ably 4 ✔ Unknown opsy findings available
cords, law requir has been see 2 should	Completed		autopsy perform	prior to c	ompletion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical 26. Place of Death (Check o	1 Yes 2	No 1 Ye	s 2 No
Vital hysician: this certif	To Be	10,165 2,100	Home 5 R	esidence 6 🗸 Other	Scene
rn of viding Ph		27 Manner of Death 28a Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	w injury occurred	
Division tal or Attendii rs after death, al Director: A	ficat	2 Accident Investigation	28f. Location (Str	reet and Number or Rui	al Route Number, City
Divis	Certification:	4 Homicide determined (Specify)	or Town, Sta	ite)	
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated	,		
F ≱ € 8	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	th, Day, Year)
<b>9</b> .		Patu Gronica Folloh is O.C.M.E.		January 9, 2007 —————	
0		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore</li> </ol>	e, MD 21201		
	ate	31. Date filed (Month, Day Year) 1 2 2007 Register's Signature			
Regis	lieli	ALLIA T M PANIL MEDITION NO. MANAGEMENT			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 4:00 P M 2007 Evelyn Martin January 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett 123 Steyer Mine Road Oakland If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Yrs. 1926 Maryland 18, Director 233-66-5739 80 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or iteme 23e or 28e-f ehow the Medical Exampler must be notified at 1 ☐ Yes 2 😾 No Director MD 0akland Garrett 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 123 Steyer Mine Road 21550 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Florist Floral Designer permit. Pages t end 2 should be file.
Department of Health and Mental Hyg
Important: if Item 27 is marked other
any njury or other traum-\*\*-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be O'Brien Nina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Steyer Mine Road, Oakland, MD 21550 Mr. Wayne Martin, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cumberland, MD Cumberland Crematory 1/7/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burdock-Durst Funeral Home 21 N. Second St., Ua

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line. 21 N. Second St., Oakland, MD 21550 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner Physicien: The law requires that the death certificate be executed ete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 🖼 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificete has 1 ☐ Yes 2 100 funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner: Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel L \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. 29a. Certifier Medical 29b. Signature and title of pertiti 29c. License number 29d. Date signed (Month, Dev. Year) D23979 01/05/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Goralski M.D. 311 N. Fourth St., Oakland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2007 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene

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					Cer	titicate	e of I	Death			Reg. No.		
Dhara	:-:	1. Decedent's Name (First, Middle, L						2. Date of De Month	Vana	3. Time of Death			
Physi /Me	ician dical	Carrie Eliz	abeth Nic	ckoles						Jan.	03 2	0 0 7	6:25PM
Exam		4a. Facility Name (If not institution, g	ive street end number	)			4	b. City, To	wn, or Lo	ocation of Deat	4c. Count	y of Death	
		Autumn Woods A	ssisted I	iving				West	min	ster		Car	roll
Funera	al	Social Security Number     6.		ge (In yrs. last b	oirthday)	if Undar			24 Hrs.	8. Date of Bir (Month, De	th	9. Birthpla	ce (State or Foreign
Directo		219-40-7058	1□M 2∏xF	97	Yrs.	Months	Days	Hours	Min.	Mar.	31 <b>,</b> 190	9 Mar	vland
<b>D</b> .		Usual Residence of Decedent											7
nylar how		10a. State 10b. County		10c. City, To	wn or Loc	cation						10	d. Inside City Limits
a Ma	ફ	Maryland Car	roll	W	estm	ninst	er						1 ☐ Yes 2 ☑ No
于 28	ē	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Countr	y?
th wi	a	2470 Collison	Dr.				211	157			1	USA	
dea Fig.	Der	11. Marital Status	12. Was Decedent Armed Forces	Ever in U,S.	13. W	Vas Decad	ent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	- 14. Ra	ce - America	n Indian,
or it	교	1 Never Married 2 Married	1 ☐ Yes 2.☐ If Yes, Give	No		Two 2			, Fuerto	nican, etc.)		ck, White, e	
ours	ğ	3√2 Widowed 4 □ Divorced	Year or Dates:				M INO	Specify:			Specif	y: Wh	ite
within 72 hours after death with tha Maryland ane, than "natural", or items 23a or 28a-f show he Macinal Examiner must be notified at	Completed by Funeral Director	15. Decedent's l (Specify only highest g	Education	16	a. Decede	ent's Usual	Occupa	ation	of work	ing.	16b. Kind of B	usiness/Indu	stry
thin e.	횰	Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired)								
Agian 4	Į	7			Homemaker						Ow	n Hom	e
al al	Be	17. Father's Name (First, Middle, Las	st)								Maiden Sumer	n <i>e)</i>	
uld b Mant rked	David Bair					P	nni	e Mum:	ford				
and I	ြ	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing	g Address	Street a	and Numbe	r or Rura	l Route Numbe	er, City or Town	State, Zip C	code)
alth alth		John W. Nickol	es Jr./So	on 3	740	Nich	ols	son F	≀d.,	West	minste:	r, MD	21157
S 1 8		20a. Method of Disposition		20b. Place cemete	of Dispos	ition (Nem	e of	e)		Date	20c. Location	City or Tow	n, State
Page nant and ry or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Lakev				-	1	/6/200	7 Syke	svil	Le. MD
permit. Pages 1 and 2 should be filad within 72 hours after death with tha Marylan Department of Health and Mantal Hygiane. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at many and a contract of the manual or notified at many and a contract must be notified at many and a contract of the manual or notified at many or any and a contract must be notified at many or any and a contract must be notified at many or any	4	21. Signature of Funeral Service Lice	<u> </u>		22.	Name and	Addres	s of Facility	,				
Per Per S	NIIK	16	1		I	ritt	s E	uner	al	Home 8	Chape	el, P	.A.
		One Posts February											, Md 21
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	y one cause on each li	ne.	not ente	r the mode	or ayıng	g, such as	cardiac c	r respiratory at	rest,	1 1	pproximate terval Between
Physiciar /Medica		Immediate Cause /Final											Inset and Death
Examine		Immediate Cause (Final disease or condition resulting in death)	a Corona	ry art	ery	dis	eas	е				2	0 years
	200	, and the second second		Due to (or as a	consequ	ience of):							
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n certificate be axecuted inding physician and use as the bunal-transit	Xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a	consequ	ence of):							
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res that tha death signad by the atter I ba detached for u	Physician	Part II. Other significant conditions	contributing to death b	ut not resulting	in the unc	derlying car	ıse give	n in Part I.		23b. Did t	obacco use co	ntribute to ti	ne cause of death?
at th	듄	Diabetes mel	litus tw	ne 2						101	res 2 No	3 Proba	bly 4 ☐ Unknow
esth igna bad	þ	- Tubeteb mei	LI Cas cy	PC Z									
v require been si should t	Completed									24a. Was	an autopsy med?		autopsy findings
m * 0	Pie Pie											comp of de	letion of cause
aw re	Ę									1 D Y	es 2.DNNo	10	′es 2□No
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rsician: The law re- s cartificate has bee diractor, page 2 sho	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	nt 2 FR/O	utnationt	3 DO V			oine Hee	an KY Doniel	anne a Doub	10	
i Physician: The law re- rithis cartificate has bee eral diractor, page 2 sho	To B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	3□ DOA	. Injury	at Nur			ence 6 □Oth		
g g	To B	examiner? 1  Yes 2 No  27. Manner of Death 1  Anatural 5 Pending	28a. Date of Inju (Month, De	ry 28b.			. Injury Work	at ?	2				
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Io the Hospital or Attanding within 24 hours aftar death.  To the Funaral Director: After completely filled in by the funa.	edical Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death 1	28a. Date of Inju (Month, De) 28e. Place of Inju building, etc  28e. Place of Inju building, etc  28e. Place of Inju building, etc  28e. Place of Inju building, etc	y Yeer) 28b. ury - At home, fi c. (Specify) of my knowledge examination arited.	Time of Injury	M 286 M occurred at stigation, ii	c. Injury Work  1  Y  office  the time n my opi	at ? Yes 2 N	o 2	8d. Describe h  8f. Location (S City or Tow  nd due to the c d at the time, c	ow injury occurrence of treet end Numb (n. Stete)  ause(s) and malate and place, a	er or Rurel F  Inner as state and dua to the	ed. a cause(s) y, Year)
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To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this cardificate has completely filled in by the funeral director, page 2	edical Certification; To B	examiner?  1	28a. Date of Inju (Month, De) 28e. Place of Inju building, etc  28e. Place of Inju building, etc  and manner sta  completed cause of de	y Yeer) 28b.  ury - At home, for (Specify)  of my knowledge examination articled.	Time of Injury  arm, stree e, death of	M 286 M December of factory, and accourred at strigation, in 29c. D print)	injury Work 1 TY office the time in my opi	at ? fes 2 N  e, date and inion, death number  4 0	place, a	8f. Location (S City or Town  and due to the c d at the time, c	ow injury occurrence of the state of Numbers, Stefe)  ause(s) and malate and place, and	er or Rurel F  unner as state and dua to the d (Month, De	ed. a cause(s) y, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** DONNA RAE PARKER /Medical 4, JANUARY 2007 9:10 A M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8721 CALLOWAY ROAD WILLARDS WICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6-23-1955 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Months Director 221-40-3770 51 MARYLAND Usual Residence of Decedent 10a. State 10b. County or 28a-f show 10c. City, Town or Location the Medical Exeminer must be notified at 10d. Inside City Limits Directo MARYLAND WICOMICO WILLARDS 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iteme 23a 8721 CALLOWAY ROAD 21874 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 TNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after Black, White, etc. 1 ☐ Never Married 2 Married 'naturel', or þ 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry UNITED STATES Elementary/Secondary (0-12) College (1-4or 5+) MAIL CARRIER POSTAL SERVICE marked other 17. Father's Name (First, Middle, Last) Be and Mental ! 18. Mother's Name (First, Middle, Maiden Sumame) AUBREY DENNIS ဥ CARRIE TRUITT 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DALE E. PARKER, JR/ HUSBAND item 27 8721 CALLOWAY RD., WILLARDS, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Importent: if it eny injury or o 20c. Location - City or Town, State 1 Burial 2 Crement 3 Removal from State 4 Donation TRUITT CEMETERY 5 Other (Specify) 1-7-2007 POWELLVILLE, MARYLAND 21. Signature of Funeral MELSON FUNERAL SERVICES, LTD, THATCHER STREET, FRANKFORD, DE 19945 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate
Interval Between
Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) Month Day 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 s 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2₽ No 2X No director 25. Was case referred to medicat Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 1 ☐ Yes 2 🙀 No Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) this 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of the Hospital or Attending 28d. Describe how injury occurred 1 XNatural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and BA 6

Registrar DHMH 17 Rev 1/2001

State

0.

(Month; Day, Year)

JAN 0 9 2007

31. Date file

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760

Division of Vital

E. CAMOUST.

145

32. Pagistrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - State Registrar  1. Decedent's Name (First, Middle, Las		Ce	rtificate of			Rag. No.	7 01368
	Physic /Medi	cal	Sylvia L.	Prout				2. Date of Dea	Day V.	3. Time of Death <b>10:30 P</b> M
}	Exami	ner	4a. Fecility Name (If not institution, give 3005 Alexander Pla	street and number) ace		4b. City, Town, o Bowie	or Location of Death	h	4c. County of C	George's
	Funeral Director			x □M 2∑XF 6(	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 11-9-1	v, year)	Birthplace (State or Foreig Country) shington, DC
	aryland	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	r 28e-f	recto	Maryland Prince Ge	eorge's	Bowie	10f. Zip Code			10g. Citizen ot Wha	1√2 Yes 2 □ No
	ath with	ralD	3005 Alexander Pla	ice		20716			United S	•
9036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f show ta Madical Exertine must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes 2 N If Yes, Give Year or Dates:	lo	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. Black
21215-0036	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23s or 28e-f show any Injury or other treumatic event, the Madical Examines must be notified at ODGe.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5	T/		nation during most of word t) ctor/Oper		16b. Kind of Busine Fort Line Cemetery	,
<b>Maryland</b>	id be filed ental Hyg ked other c event,	To Be C	17. Father's Name (First, Middle, Last) William Lloyd Baf	ford				ne (First, Middle,	Maiden Sumame)	
lary	2 shou and M is mar eumat	-	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailin				r, City or Town, Stat	e, Zip Code)
	eges 1 end nt of Heelth t: If Item 27 / or other tr		Robert Prout (hus 20a. Method of Disposition  X Burial 2 Cremation 3 F		20b. Place of Disportant Commetery, crem	Alexander Sition (Name of salory or other place	e <b>e</b> )		20c. Location - City	,
Baltimore,	permit. P Depertme Important eny Injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	98			ss of Facility Fo	rt Linco	Brentwood,	al Home
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition			or the mode of dyin	U		est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		consequence of):					
	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence ot):					
00/00	rtificate be executed ng physicien and es the burial-transit	Aedicai Ex	resulting in death) Last	Due to (or as a	consequence of):					
	death ce e attendii id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 ②No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3 1	Ectopic pregnancy Other (specify)			23d. Date of o	detivery Day Year
r (SDIO	equires thet en signed b ould be deta	ρχ	Part II. Other significant conditions con	tributing to death bu	not resulting in the un	derlying cause give	on in Part I.	23e. Did tob		to the cause of death?  Probably 4 □Unknown
שו חשכ	ding Physician: The law requires thet the After this certificete has been signed by th funeral director, page 2 should be detache	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death	autopsy findings avaitable o completion of cause of ?
5	ysicla is certii directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	t 2 ER/Outpatient	3□ DOA Othe	26. Place of Death		4	
-	5 E	ation: T	27. Menner of Death  1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28c. Injury Work	4 Li Nursing Ho	me Fiz Reside 28d. Describe ho	nce 6 Other (Sp w injury occurred	pecify)
	itei or Attencirs after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, tarm, stree (Specify)	et, factory, office		28t. Location (Str City or Town,	eet and Number or i , State)	Rural Route Number,
	he Hospi n 24 hou he Funer pletely fill	edicai	one)	cian: To the best of er: On the basis of e and manner state	my knowledge, death oxamination and/or inve ed.	occurred at the time stigation, in my opi	e, date and place, a	and due to the ca ed at the time, da	use(s) and manner te and place, and di	as stated. ue to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	1		29c. License DC 19		29	d. Date signed (Mor	nth, Day, Year)
_(	3)		30. Name and address of person who cor John L. Marshall	npleted cause of dea	ith (Item 23a) (Type, P 8800 Reserv	rint)		shington	1/4/2007 DC 2000	7
	Stat Registra		31. Date filed (Month, Day, Year)		s Signaturs		, ,			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** JANUARY 2007 FLORA G. POLLARD 1:50 a <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Oct. 28, 1911 North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 ☐ M 2 🖾 F 95 Director 578-38-9279 Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Exercitar must be notified at M∑Yes 2 No Director DC Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 46th St. N.E. 20019 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐Widowed 4 ☐ Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "any injury or other traumatic event, the Messary injury or other traumatic event, the Messary injury or other traumatic event, the Messary other. Elementary/Secondary (0-12) College (1-4or 5+) 2yrs National Security Dept. of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel M. Chappell ပ Maggie Tillman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye Mason/Niece 210 46th St. N.E. Washington, DC 20019 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 1-9-2007 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Laurel, Md. 21. Signa)(Tip of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011 23a. Part1. Enter the disease, or complications that caysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (op as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a cons The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ettending physicien for use es the buria Box 68760 ician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2♣ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the detached P.O. Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificete 2 🗀 No Division of Vital 1□ Yes 2 XNo 1 TYes Physician: ours after death.

erel Diractor: After this certific
filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Naturat 5 Pending Injury 1 Yes 2 No 2 🗆 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funerel ( 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical completely 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur and title of certifier 29d. Date signed ( onth, Da Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARRELL MESREEN ANGO 1610 31. Date filed (Month, Day, Year)

JAN 0 4 2007 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmen			Mental H	ygien Reg. N	$Z \oplus U$	7	01370
	Physici	an	1. Decedent's Name (First, Middle, La.	A =	ab.u				2. Date of I Month		ay	Year	3. Time of Death
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	Examir	er	4a. Facility Name (If not institution, give			1		Location of Dea			c. County o		7702
	Funeral	*	5. Social Security Number 6. S		(In yrs. last birthday	If Under	1 Year	If Under 24 Hr	s. 8. Date of B	lirth			lace (State or Foreign try)
	Director		194-14-7790 Usual Residence of Decedent	□ M 2 <b>X</b> □ F	82 Yrs.	Months	Days	Hours Mir		10 1			sylvania
	yland		10a. State 10b. County		10c. City, Town or L	ocation						10	Od. Inside City Limits
	a-f st	ctor	Maryland Washi	ngton	Hagers	town							1 ☐ Yes X☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural, or Itams 23a or 28a-f show entry filury or other traumatic svent, the Medical Estimitation at most in a page.	Funeral Director	10e. Street and Number 13630 Donnybroo	k Drive		10f. Zip		742		10g. C	itizen of W U.	hat Coun	try?
	ams ams	iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Deced	lent of His	panic Origin? ( , Mexican, Pue	Specify Yes or f	No-	14. Race Black	- America	
036	ors after	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗓 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,			Whi	
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ylaı	ould be Mental arked o	ဂ္	Michael Knapp				i i		ra Orya				
Maryland	2 short and and raum		19a. Informant's Name/Relationship (			-			Rural Route Nurr	-			
	1 and Health em 27 ther t		Walter V. Prokopi 20a. Method of Disposition	k (nusband	20b. Place of Disp			OOK DIT	ve nag		OWII I'I		and 21742 wn. State
nor	ages int of t: M Its		1 ☑ Burial 2 ☐ Cremation 3 ☐		Rose Hil	matory or of	ther place		9-2007			•	Maryland
Baltimore,	nit. P artme ortan ortan Injury		4 ☐ Donation 5 ☐ Other (Specification 21 Signature of Funeral Service Licer										
Ba	Depariment of the permit of th		Muchos	Lew	13	331 Ea	ster	n Blvd.	N. Hag	erst	own Ma	runei aryla	ral Home and 21742
E. F.	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. SMALL CELL CARCINOMA LUNG  Due to (or as a consequence of):  b. Due to (or as a consequence of):  Cause (Disease or injury that initiated events  c.										
x 68760,	ertificate be executed ling physicien and e as the burial-transit	icai Ex	resulting in death) Last	d	consequence of):								
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a	ding Phyeician: The lav h. After this certificete has funeral director, page 2	မ င	25. Was case referred to medical					00.00	1 ☐ Yes	2 <b>X</b> N		Yes	2 🗌 No
Vital	s certi	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	nt 3 DO	Other		eath <i>(Check only</i> Home 5 🗆 Re		6 □Other	(Specify	1
J Of	g Phy erthis eral c		27. Manner of Death	28a. Date of Injury (Month, Day			8c. Injury a Work?		28d. Describe				/
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	To the Hospitel or Attentwithin 24 hours after deal To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of iner: On the basis of and manner stat	examination and/or in	h occurred a vestigation,	at the time in my opi	n, date and place nion, death occ	e, and due to th curred at the time	e cause( e, date ar	s) and man nd place, ar	ner as stand due to	ated. the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier			29c.	. License	number		29d. D	ate signed	(Month, E	Day, Year)
1	8		Koraun m	2		I	200	4723	4	11	6/0/	)	
0	Q		30. Name and address of person who	completed cause of de									
	3		10 0 11 11 1000	MD 134.		VSYL	VANI	A AVE	HAGO	ERS7	OWN	M	21742
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	s Signature	bethe	,						

			For AMENIOH10	State o	f Marylar				nd Mental Hy	/giene		
			1 - State AMEND#10eper Registrar AMEND#4aper	лні/16/07 <b>,</b> 101/16/07 <b>,</b> В	HMW,MbCb MW.MbCb	Cei	rtificate of	Death		Reg. No.	107	01371
1	Physici	an	Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic			ONARD PATTE		·			JANUARY	1, 2007		11:15 A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, 12320		mber)		4b. City, Town, or				inty of Death	37
, it			1320 PRETORIA	DRIVE 6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	ER SPRI			NTGOMER	
ĸ.	Funeral Director		007-26-6348	1 □ M 2 🔏 F		Yrs.	Months Days		Min. (Month, D	ay, Year)	9. Birthp	
			Usuai Residence of Decedent		75				MAY 20	<b>, 1</b> 931		MAINE
	yland how		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation		-		1	IOd. Inside City Limits
	e Mar a-f s tified	ctor	MARYLAND MONTGO	OMERY			SILVER SPR	ING				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number 12320				10f. Zip Code			10g. Citizen	of What Cour	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	La	12320 PRETORIA	DRIVE				20904			U.S.A.	
	er de tems	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origii an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. F	Race - Americ Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	if Yes, Giv	/e		1 ☐ Yes 2 🛛 No	Specify:			cifv:	
Ş	hour tural	pa k	15. Decedent's	Year or D	ates.	16a Dece	lent's Usual Occup	ation			W	HITE
15	in 72 n "na Aedio	plet	(Specify only highest	grade completed)		Give	kind of work done o	during most o ()	of working	100. Kilid ol	f Business/Ind	dustry
21215-0036	d with giene rr tha	Completed	Elementary/Secondary (0-12)	College (1	-40r 5+)		SECRETARY			U.S.	GOVERN	MENT
	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, L	ast)				18. Mother's	Name (First, Middle	, Maiden Surr	name)	
Maryland	Ment Ment irked	To	DAVID LEONAL	SD O					ELLA CRANDAL	L		
ar	2 sho and Is ma		19a. Informant's Name/Relationshi	(Type. Print)		19b. Mailir	g Address (Street a	and Number	or Rural Route Numb	er, City or Tov	vn, State, Zip	Code)
	and lealth m 27 her tr		LINDA P. HALL	- DAUGHTER				RY ROAD	, PULASKI, V	IRGINIA	24301	
Ore	ges 1 t of H If ite or ot		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation	B □Removal from		Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Locatio	n - City or To	wn, State
Ē	t. Pa tmen tant: ijury		4 □ Donation 5 □ Other (Spe	ecify)			EMORIAL PAR		/4/2007	FALLS	CHURCH,	VIRGINIA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	censee	+.	22   H	. Name and Addres INES-RINALD	s of Facility I FUNER	AL HOME, INC			
	40260		Nancy A.	Via cem	- 14	1	1800 NEW HA	MPSHIRE	AVENUE, SIL	VER SPRI	NG, MAR	YLAND 20904
	Table 1		23a. Part1. Enter the visease, or c shock, or not flure. List o	omplications that can be on each	aused the deat ach line.	in. Do not ente	er the mode of dyin	g, such as ca	ardiac or respiratory a	rrest,		Approximate interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- u.	ASTATIC		CER					Onset and Death
0	Examiner			Due to (	or as a conseq	juence of):						
\$1		er	Sequentially list conditions, if any, leading to immediate	b Due to (	or as a conseq	juence of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								1	
oʻ	exec an an rial-tr	Exa	resulting in death) Last	Due to (	or as a conseq	uence of):						
58760,	ficate be executed physician and is the burial-transit	dical		d								
	rtifica ng ph		IF FEMALE.			_						
P.O. Box	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come pf pregna irth 2 🗆 Feta		Ectopic pregnancy			23d. I	Date of delive	ry
<u>.</u>	at the dea by the at stached fo	Sici	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		ant at time of o		Other (specify)			'	Month	Day Year
	d by t	P <sub>P</sub>										
Records,	luires tha signed I	þ	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the un	derlying cause give	n in Part I.				e cause of death?
000	w requ	Completed							_   '⊔	Yes 2□ No	3 A Proba	ably 4 ☐Unknown
3ec	The law ate has t page 2 s	nple							24a. Was	OSV	b. Were autop	osy findings available npletion of cause of
_	r: Th icate ; pag	ဒိ							perfo 1□ Yes	rmed? 2 No	death?	2 No
Vital	slclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho		Death (Check only of			
ō	Phy:	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date o		ER/Outpatient 28b. Time of		4 LI Nursii	ng Home 5 Resi			')
Division or	ding h. Afte fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Monti	h, Day Year)	Injury	28c. Injury Work	ai ? ′es 2∐No	28d. Describe	now injury occ	urred	
/ISI	after death after death Director: ,	fica	3 Suicide 6 Could no	be 28e. Place	of injury - At ho	ome, farm, stre	et, factory, office	20 110		Street and Nur	nher or Rural	Route Number,
Š	al or after after d in b	Certification:	4 ☐ Homicide determine	buildir	ng, etc. (Specif	(y)	, , ,		City or To	vn, State)	ilber of flatar	noute Number,
	To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certifics completely filled in by the funeral director; p	a	29a. Certifier 1 Certifying	Physician: To the	best of my kno	wledge, death	occurred at the tim	e, date and p	place, and due to the	cause(s) and i	manner as sta	ated.
	n 24 n 24 he Fu	Medical	(Check only 2 Medical Ex	a <b>miner:</b> On the ba and mann	sis of examina	ition and/or inv	estigation, in my op	oinion, death	occurred at the time,	date and place	e, and due to	the cause(s)
		Σ	29b. Signature and title of certifier	7.	1.		29c. License		1	29d. Date sigr		*
	5		Cepithia)	n Mu	lion	20,00	HOO	5803	32	1-2	-200	07
			30. Name and address of person wh	no completed cause	of death (Item	1 23a) (Type, F	rint)					
			CYNTHIA M. WILL	-			ICE, 6001 M	UNCASTE	R MILL ROAD,	ROCKVIL	LE, MARY	YLAND 20855
	Stat Registra		31. Date filed (Month, Day, Year)	007	egistrar's Signa	ture	18° )					

			1 - For State Registrar	State of M	aryland		artment of H tificate of I			giene Reg. No.	07	01372
	Physicia		Decedent's Name (First, Middle, L Amoge		Pea	rson			2. Date of Dea January		7 <sup>Year</sup>	3. Time of Death 5:40 PMM
	/Medic Examin		4a. Facility Name (If not institution, ga Golden Living				4b. City, Town, or Freder	Location of Death	1	4c. County Fred	of Death erick	ζ
Ī	Funeral Director		5. Social Security Number 6. 443–12–2812	Sex 7. Ag	96 :	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	July 3	1910	9. Birthp Ok La	place (State or Foreign homa
	ס	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Freder:	ick		, Town or Lo				•	1	0d. Inside City Limits
	with the	I Direc	10e. Street and Number 30 North Place				10f. Zip Code 2170	)1		10g. Citizen of V		ntry?
020	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Dapertment of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Iteme 23a or 28e-f show eny injury or other traumatic event, the Medical Examitter court be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Ovorced	12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	?	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spanic Origin? (Spanic Origin) (Specify:	pecify Yes or No- o Rican, etc.)		e - Americk, White,	etc.
5	in 72 ho "natur	Completed	15. Decedent's (Specify only highest g	rade completed)	5.1	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor	king	16b. Kind of B	usiness/Ind	dustry
7 7 7	iled with tygiene. ther ther nt, the N	Com	Elementary/Secondary (0-12)	College (1-4or	5+)	Admi	nistrativ	7e Assist		Electr:		moany
) ia in	Mental H Mental H arked ot atic ever	To Be	Colin Albert W					Ada B	ell Dono	oghey		
Ma	nd 2 sho alth and 27 le m		19a. Informant's Name/Relationship D. Bob Pearson,			19b. Mailir 1000	ng Address (Street a Mercer I	Place, Fr	ederick	or, City or Town, Maryla	State, Zip and	21701
allinore,	Pages 1 a ment of Hes ant: if Item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		20b. Pl	klawn	sition (Name of matory or other place Cemetery			20c. Location - Sulphui	c, Ok	
ם ם	permit. Dapert Import eny inj		21. Signature of Funeral Service Lic	1	M0025	$5 \begin{vmatrix} \frac{22}{K} \\ 1 \end{vmatrix}$	Name and Address Reeney and O6 East	s of Facility d Basford Church St	d PA Fun	eral Ho erick,	me MD 21	1701
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that cause y one cause on each li	d the death ine.							Approximate Interval Between Onset and Death
Ċ	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as	e me		1					
	3	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury that initiated events	b. Due to (or as	a consequ	uence of):						
0/00,	cate be executed physicien and ; the buriat-transit	dical Ex	resulting in death) Last	Due to (or as	a consequ	uence of):						
O. DOX 00	alcian: The law requires thet the death certifica certificate has been signed by the attending phrector, paga 2 should be delached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 20 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,			te of delive	ery Day Year
Cords, P	equires thet en signed by ould be deta	Ď	Part II. Other significent conditions  Severe	contributing to death to	but not resu	ulting in the u	nderlying cause giv	en in Part I.		1	ribute to th	he cause of death? pably 4 □Unknown
ב	n: The law r icate has be r, paga 2 sh	Completed								rmed? 2 M No	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
ı VII	hysiciar his certif I directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1  Inpati	ent 2 🗆 I	ER/Outpatier	it 3 DOA Oth	er +	th (Check only on ome 5 ☐ Resid		er (Specif	y)
	Attending Physician: or death. ector: After this certifice by the funeral director, i	atlon:	27. ManAer of Death 1 Natural 5 ☐ Pending 2 ☐ Accidentinvestigati		ury ay Year)	28b. Time of Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe h	now injury occur	red	
DIVISION	N or Atte efter de I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	A 280. Place of in	jury - At ho tc. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f. Location (5 City or Tox		er or Rura	i Route Number,
	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, paga	edical C	29a. Certifier 1X Certifying I (Check only one)	Physician: To the best aminer: On the basis of and manner st	of examinat	wiedge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, or	cause(s) and made and place,	anner as si and due to	tated. the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier				29c. Licens	e number	7	29d. Date signe Januar		
ŧ	4		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type,	Print)	16041	/	4		21702
	Sta	ite	Hemen Shah 31. Date filed (Month, Day, Year)	32. <b>G</b> gist	rar's Signal	Thor	has Joh	msm	Dr. F	redev	CK	MD
	Registr		8 0 MAL	2007	was	B A	park					

07-00143	
Susan Proctor	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician   10-beedent's Maree (First, Middle, Last)   2 Date of Death Month Day Vest   2 Timefor Death On 113 hrs   2 Date of Death Month Day Vest   2 Timefor Death On 113 hrs   2 Date of Death Month Day Vest   2 Date of Death Month Day Vest   2 Date of Death Month Day Vest   2 Date of Dea	susan Proctor		1- For State Registrar Certificate of Degrate		eg. No nan	7 0107	
As faculty tended on the popular in		an/	Decedent's Name (First, Middle,Last)				
Second Science   Price of the price of the			4a. Facility Name (if not institution, give street and number)  4b. C	ity, Town, or Location of Deatl		4c. County of Death	
215-92-2416	Francis		,		8 Date of B		thniana (State or
Total State   State			215-92-2416 1 M 2XF 43 Yrs.		1	Foreig	ın
The second of the second secon	, any	ı					10d Inside City Limits
The second of the second secon	yland -f shov once.	į		7.0			1 Yes 2 X No
George T. Herbert/ Father    P.O. Box 264, Clements, Maryland 20624	he Mar or 28a ifred at	Direc		·		-	
George T. Herbert/ Father    P.O. Box 264, Clements, Maryland 20624	th with 1 ems 23s	eral	11. Marital Status 12. Was Decedent Ever in U.S 13. Was De-	cedent of Hispanic Origin? ( S	pecify Yes or No	o- 14. Race - Ameri	
George T. Herbert/ Father    P.O. Box 264, Clements, Maryland 20624	fter dea		3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:		Specify B1.	ack
George T. Herbert/ Father    P.O. Box 264, Clements, Maryland 20624	nours a natura	ed b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Unique most of	sual Occupation (Give kind of			
George T. Herbert/ Father    P.O. Box 264, Clements, Maryland 20624	136 thin 72 te. than "	nplet				Restauran	t
George T. Herbert/ Father    P.O. Box 264, Clements, Maryland 20624	15-0C filed wii Hygier d other					Maiden Surname)	
George T. Herbert/ Father    P.O. Box 264, Clements, Maryland 20624   Control of the Specify   Date	2127 uld be Mental marke					mber, City or Town, State	, Zip Code)
22 American Address of Finality Brinsfield Funeral Home, P.A.	O 5 5 5 €		George T. Herbert/ Father P.O. Box	264, Clement	s, Mary	land 20624	
22 American Address of Finality Brinsfield Funeral Home, P.A.	Ore, ges lan t of Hea . If iter		1 X Burial 2 Cremation 3 Removal from State crematory or other pl	lace)			
Physician Medical Staminer    239 Part Einfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line failure. List one cause or each line failure. List only one cause or each line failure. List only one cause or each line failure. List one cause or each line failure. List one caus	Iltim nit Pag artinent ortant:						
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State    State   Continue   Conti			failure. List only one cause on each line	ode of dying, such as cardiac	or respiratory arr	rest, shock, or heart	Approximate Interval Between Onset and
To Company of the control of the con	Examiner						Deali
The state of the s	**prod	er	Sequentially list conditions,				
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The part of the pa	scuted and transit		Conto residing in dealing East				
The part of the pa	O, e be exe ysician burial -	edic					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e Drd tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a Was an audiopsy performed?   1   Yes 2   No 3   Probably 4   Unknown 24a	6876 ertificat ding phy		23b Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal de	eath 3 Ectopic pregna	ancy	· · · · · · · · · · · · · · · · · · ·	
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29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  January 6, 2007  30. Name and address of person who completed cause of death (Item 23a)  Mary O. Ripple MD. Deputy Chief Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filled (Month Day, Year)  32. Registrar's Signature	.O. E hat the ed by th		Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.			
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  January 6, 2007  30. Name and address of person who completed cause of death (Item 23a)  Mary O. Ripple MD. Deputy Chief Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filled (Month Day, Year)  32. Registrar's Signature	dS, P quires t en sign uld be o	ted t					
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29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  January 6, 2007  30. Name and address of person who completed cause of death (Item 23a)  Mary O. Ripple MD. Deputy Chief Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filled (Month Day, Year)  32. Registrar's Signature	on o ending ath. or: Afte	tion:	1 Natural 5 Pending Jan 6, 2007 0028 hrs				
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  January 6, 2007  30. Name and address of person who completed cause of death (Item 23a)  Mary O. Ripple MD. Deputy Chief Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filled (Month Day, Year)  32. Registrar's Signature	ivisi I or Att after de Directe	tifica	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, fac	ctory, office building, etc	or Town, S	State)	,
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  January 6, 2007  30. Name and address of person who completed cause of death (Item 23a)  Mary O. Ripple MD. Deputy Chief Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filled (Month Day, Year)  32. Registrar's Signature	D lospital f hours uneral		29a. Certifier a Continue Physician To the heat of an Institute death	at the time, date and place, and	Chancellors F	Run Road at Belvoir R	72. 10. 10. 10.
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  January 6, 2007  30. Name and address of person who completed cause of death (Item 23a)  Mary O. Ripple MD. Deputy Chief Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filled (Month Day, Year)  32. Registrar's Signature	o the H vithin 2- o the F	dica	one) 2 Medical Examiner: On the basis of examination and/or investigation, i				
30. Name and Address of person who completed cause of death (Item 23a)  Mary C. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Mont Deputy Car) 32. Registrar's Signature		ž	29b. Signature and title of certifier				nth, Day Year)
Mary O. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date (Mont) Deputy Cap 32. Registrar's Signature			30. Name and address of person who completed cause of death (Item 23a)	O.O.IVI.E.		January 6, 2007	
			Mary O. Ripple MD. Deputy Chief Medical Examiner 111 Pe	enn Street, Baltimore, N	/ID 21201		

DHMH 17 Rev 1/2001 OCME 2006

		1 - For Stete Registrar	State	of Maryla			t of Hea e of De		Mental H	ygiene Reg. No	CUU	7	01374
	-0	1. Decedent's Name (First, Middle	e, Last)		-				2. Date of I			ā.	3. Time of Death
Physic /Medi		Gillian Bla	nche Rado	cliffe					Januar	y 2,		ar	2112 p <sup>M</sup>
Exami		4a. Facility Name (If not institution				4b. City,	Town, or Lo	cation of Dea			County of [	Death	
		26291 Norfolk I	rive			De	elmar				Wicom	ico	
Funeral		5. Social Security Number	6. Sex	7. Age (In yr.	s. last birthday)	If Under Months		Under 24 Hr. Hours Mir	8. Date of E	Birth Day, Year)	9.	Birthpl	ece (State or Foreign
Director		183-54-8194	1 ☐ M 2 🖾 F	63	Yrs.				June	10, 19	943		Íand
pud .		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation						10	d. Inside City Limits
sho	5		-i		Delmar								1 ☐ Yes 21 No
288-1	Director	MD Wicon	1100		Dellial	10f. Zip	Code			10g Cit	izen of Wha	I Count	ry?
With Party		26291 Norfolk I	\				21875					_	,,
eath	Funerai	11. Marital Status		cedent Ever in	U.S. t3.			anic Origin? (	Specify Yes or I	_	Inglan		an Indian,
fer d	F	1 ☐ Never Married 25X Marr	Armed F				_		Specify Yes or f rto Rican, etc.)		Black, V	White, e	tc.
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	live Dates:		1 🗌 Yes	2⊠No S	Specify:			Specify:	1	white
2 ho	Completed	15. Deceden		1	16a. Deced	dent's Usua	al Occupatio	n ng most of wo	ndrina	16b. K	ind of Busin	ess/ind	ustry
thin 7	ple	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT US	se retired)	ng most of we	Jiking				
er th	Sol	12				Hor	nemake				Home		
be filed within 72 hours after death with the Manyland lat Hygiene. d other than "neturel", or iteme 23e or 28e-f show event, the Medical Examinat must be notified at	Be	17. Father's Name (First, Middle,					18		me (First, Midd				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or iteme 23e or 28e-f show any injury or other treumstic event, the Medical Examinat must be notified at once.	2	Arthur Ernest		rior					ance Ev				
2 sh 2 sh 3 and 1 s m		19a. Informant's Name/Relations		. 1					lural Route Nuπ			te, Zip (	Code)
fealth and and and and and and and and and and		John J. Radcli	life (hus		Place of Dispo		olk D	rive	Delmar,	· ·	21875 ocation - City	, or Tou	en Stata
S = S		1 △Burial 2 ☐ Cremation		China	cemetery, cren	natory or o	ther place)	I					
tant:		`4 □Donation 5 □ Other (S)			eterans	Ceme	tery		8,2007	Hur	lock,	Mar	yland
Departiment of the control of the co		21. Signature of Funeral Service			Sh	ort l	d Address of unera	1 Home	elmar,				
40200				Samuel the de							9940		Approximate
	Ę	23a. Part 1. Enter the disease, or shock, or hear failure. List	only one cause on	0			e or dying, s	uch as cardia	ic or respiratory	arrest,			Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		roma	,							ZWKS
Examiner			Due to	(or as a conse	equence of):								
	2	Sequentially list conditions,	b. — Due to	(or as a conse	quence of):								
nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,								
execu n and al-tra	xai	that initiated events resulting in death) Last	c	(or as a conse	quence of):		<del></del>					-	
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicail		l a										
ificate g phy as the	0		0.										
eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Cataniana					23d. Date of	deliver	у
death death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4∐Preg	birth 2 ∏ Fei nant at time of		Ectopic pr Other (sp					Month	Į	Day Year
that the de	hys	9 Unknown	9□ Unki	nown		····							
w requires that been signed to should be det	by P	Part II. Other significent condition	ons contributing to	death but not re	sulting in the ur	nderlying ca	ause given ir	n Part I.				e to the	cause of death?
en si									1 [	Yes 2	□No 3□	Proba	bly 4 ∐Unknown
e law re has be	plet								24a. Wa	s an opsy			sy findings available pletion of cause of
The ste hg	Completed								per	formed?	deat	h? Yes 2	
sician: The certificate hi	Be C	25. Was case referred to medical examiner?					26	. Place of De	ath (Check only	one)	1		
d is	Tol	1 Yes 2 No	Hospital: 1	Inpatient 2	☐ ER/Outpatien	t 3□ DO	A Other:	4 🗌 Nursing l	Home 5 Re	sidence (	6 □Other (5	Specify)	
ng Pl	on:	27. Manner of Death 1 □ Natural 5 □ Pendin	28a. Date (Moi	of Injury oth, Day Year)	28b. Time of Injury		Bc. Injury at Work?		28d. Describe	how injur	y occurred		
eath.	cati	2 Accident investig	ation of he			М		2 🗆 No					
lor Att	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 200. Place	e of Injury - At I ling, etc. (Spec	home, farm, stre efy)	et, factory	, office			(Street and own, State		r Aurai	Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely illed in by the funeral director.		200 00 000	- 05					4-4					
Hosp 14 hol Fune tely fi	edical	(Check only 2 Medical I	g Physicien: To th Exeminer: On the l	pasis of examin	ation and/or inv	estigation,	in my opinio	on, death occ	urred at the time	e cause(s) e, date and	and manne place, and	r as sta due to t	ted. he cause(s)
thin 2 the The	Med	one) 29b. Signature and title of centreer	and mar	ner stated.		290	. License nu	ımber		29d. Dat	e signed (M	onth. D	av, Year)
To Yeild			1				150	1/7.3			1	1	A THEORY
INTEN		20 Name and address of account	ubo completed and	rea of death ()+-	m 23a) (T	Print'	/	7			1/3/	0 1	
6		30. Name and address of person of DAVIS	mb completed cau	100 Pr	om 23a) (Type. I	5+.	Sa	lista.	a M	no	715	zn.	f.
Sta	ate	31. Date filed (Month, Day, Year)	32.	egistrar's Sign	nature	,		1000	7/		- C	107	
Regist	-	JAN 05	2007	MILLER	H 60	ach		`	$\circ$				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U / Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav Year /Medical MARY ANN STERLING Constituy second 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Princess AIII.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Time 8, 1926 Somerset Manokin Manor Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F Director Yrs. 215-20-4252 Usual Residence of Decedent 08 Virginia death with the Maryland r 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Somerset Crisfield Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itams 23a or 21817 <u>3254 Sackertown Road</u> USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H tent: If item 27 is marked out Be 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Pete Purcell Lena Poulson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Everbart (Daughter) 34055 Old Hickory Road - Laurel, Delaware 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If Ite any injury or ot once. Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2007 Asbury Cemetery Crisfield, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Bradshaw & Sons Funeral Home
306 W. Main Street - Crisfic
30a. Partl. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4/2 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Year signed by the a' Day 1 🗆 Yes 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 K No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation ↑ Yes 2 No Director: within 24 hours after der To the Funeral Directo completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} ŏ To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) elgour ch. 505 2. Name and advises of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

GREGORIOM. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801

**ORIGINAL** 

Λπ	andad -	ite	For Amend Item 24a pt m Registrar #26, per phy	State of Marylan Twans 1,880,0	3/29/07/ Cei	tificate	t of Heal	th and Math B.A	Mental Hyg	giene Reg. No 20	0.7	013	76
All	Physici		Negsala   20, per phy     Decedent's Name (First, Middle, Last)  Viola Donoway		,				2. Date of Dea	ath Day	Year	3. Time of t	
4	/Medic	al	4a. Fecility Name (If not institution, give st			4h City	Town, or Loca	tion of Death	January	y /	2007	12:20	РМ
Q.	Examin	ier	9019 Allenswood F			, ,	dallst		,		timor	'e	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	ast birthday)	If Under	1 Year If U	Inder 24 Hrs.	8. Date of Birt (Month, Da		9. Birth	place (State or	Foreign
	Director		220-28-0015	M 201 72	Yrs.	Months	Days Ho	ours Min.	Jan. 1	<b>,</b> 1935	MD		
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	/, Town or Lo	ncation						10d. Inside City	v I imits
	Aaryla   •ho	5	MD Worceste		an Cit							1XXYes	
	the N	Director	10e. Street and Number	1 000	an cre	10f. Zip	Code			10g. Citizen of	What Cou	ntry?	
	3a or		10340 New Quay Rd.				21842			USA		,	
	death	Funeral		2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced	lent of Hispan	ic Origin? (S	pecify Yes or No		ce - Ameri	can Indian,	
9	after or its	교	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes	·	ecify:	o 1 (1001), 0(0.)	Speci	ldh i		
21215-0036	J within 72 hours after death with the Maryland Jone. I than "natural", or itame 23a or 28a-f ehow The Medical Exacular must be profitted at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	160 Dogg	dont's Lleus	I Occupation			16h Kind of 5	lucinos (In	duster	
5	in 72 nair	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of woi DO NOT us	rk done during	most of wor	king	16b. Kind of E	เนรเทศรรมเ	idustry	
212	1 withi	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Seam	stres	S			Garme	nt		
פ	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)						ne (First, Middle,	Maiden Suma	me)		
lai	should be fand Mental Pand Men	2	William Mason				Ne	llie 0	Godwin				
Maryland	s 1 and 2 should be filed v f Heelih end Mental Hygie item 27 is markad other t other traumatic evant, th		19a. Informant's Name/Relationship (Typ	e, Print)	i	•			ral Route Numbe				
e, P	1 and 16elth 16 27 1her t		Glenn Litsinger 20a. Method of Disposition	20h P	90 19 lace of Dispo			Rd.,	Randall Date	STOWN,			
وتو	ages nt of h		1 □XBurial 2 □ Cremation 3 □ Re	moval from State	emetery, crei YSONS	natory or o	ther place)	Jan.	11,2007				
Baltimore,	permit. Pages 1 and 2 s Depertment of Heelth er Important: If Item 27 is any injury or other trau ongs.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	1			•	i	e Burba				
Ba	Dep Impo		Can whine	Rabboite					Berlin,	•		TOTAL	
			27a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat	. Do not ent							Approximate Interval Betw	
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	/Medical		resulting in death)	Due to (or as a consequence	uence of):	ignar							
ı	Examiner		Sequentially list conditions, b.	Quaito for as a curiseu									
	led	nine	cause. Enter Underlying Cause (Disease or injury	Dile to (or de a conseq	aenos oty:								
	axecui and al-trai	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):								
8760	The law requires thet the death certificate be executed at has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai	d.							- Parks			
9	tificat ng phy as th	Medi	IE ECNAL C.										
Вох	eath certifica attending pl	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3[	∃Ectopic pr	egnancy				ate of deliv	- *	ear
0.	the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	eath 5	Other (sp	ecify)				on an	buy 1	Jai
Δ.	thet the de led by the a detached		Part II. Other significant conditions conf	inbuting to death but not res	ultina in the u	nderfyina c	ause given in	Part I.	23e. Did to	obacco use cor	tribute to I	he cause of de	ath?
of Vital Records,	uires the signed Id be del	d by	•						101	Yes 2 □ No	3 🗌 Pro	bably 4 ∏Ur	nknown
Sor	w requir been si should	Completed							24a. Was	an 24b.	Were auto	opsy findings a	vailable
Re	The taw sete has page 2 :	dwo							autop perfo 1 ☐ Yes	osy emed?	prior to co death? 1  Yes	mpletion of ca	use of
ta		0	25. Was case referred to medical				26.	Place of Dea	th (Check only o	200 No		ughter'	S
>	Physician: this certificral director,	To B	examiner?	ospital: 1   Inpatient 2	ER/Outpatier	nt 3 DC	Other: 4	☐ Nursing H	lome 5 Resid	<del>dense</del> 61⊠Ot	her (Speci	wReside	ence
0 0	ng Pt fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work?		28d. Describe I	how injury occu	rred		
sio	Attending or death.	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Yes	2 🗆 No	28f. Location (	Ctract and Num	has as O	al Courts At any	
Division	or Al efter of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	reet, ractory	/, опісе		City or Tox	wn, State)	Der Ur Auf	ai Houle Numb	Θ/,
_	To the Hospital or Attending Physician: within 24 hours elter death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, deat	h occurred	at the time, da	ate and place	, and due to the	cause(s) and m	anner as s	stated.	
	ne Ho n 24 h ne Fui	Medical	(Check only	<ul> <li>er: On the basis of examina and manner stated.</li> </ul>	tion and/or in	vestigation	, in my opinior	n, death occu	rred at the time,	date and place	, and due t	o the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	4		290	c. License nun	nber		29d. Date sign	ed (Month,	Day, Year)	
			1 Justin 9	May No			HUOF;	3714		1/8	3/07	<u> </u>	
	BA 6			mpleted dause of death (Item					bite 30			200 21	رسا
			Jeffrey MMTU 31. Date filed (Month, Day, Year)	M≥ 00 3 32. ∰gistrar's Signa		unk	in A	re o	ule 30	- Ben	-IW 1	NU ZI	511
	Sta Regist	ate rar	IAN 0 9 20		I A	porte	,						

Q	ne Hospital o 24 hours aff ne Funeral D pletely filled ir	dical Cer	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or invest and manner stated.	
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License numbe
•	18 × 0		18 Cr my	D005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	t)
	120		SHULAM WARIS 26266 ARS	ROWWOOD
	Sta	ite	31. Date filed (Month, Day, Year)  32. Registrar's Signature	
	Registr	rar	JAN 0 8 2007 Beaus & Son	the s
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		• •	e or Print in Blac				-		egible.	
		FOR	ate of Maryland /				Mental Hy	/giene	007	01277
		State Registrar		Cer	tificate of	Death	2. Date of D	Reg. No	001	3. Time of Death
Physici	an	1. Decedent's Name (First, Middle, Last)	Smith				Month	Day	2007	1940 M
/Medic Examin		4a. Facility Name (If not institution, give stree	and number)		4b. City, Town, o	r Location of Death			County of Death	
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Funeral	6	5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Yea <i>r)</i>		place (State or Foreign intry)
Director		Usual Residence of Decedent	94	115.			2-12-1	912	Mar	yland
yland now at		10a. State 10b. County	10c. City, Tov	wn or Loc	ation					10d. Inside City Limits
e Mar la-fsh tified	ctor	MD Wicomico	Salis	bury						1 ☐ Yes 2 ☐ No
vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	intry?
eath v is 23a nust	eral	129 Hartford Road	as Decedent Ever in U.S.	13 W	2180		necify Yes or N	USA	A 4. Race - Amer	ican Indian.
fter d	Funeral	1 □ Never Married 2 🕅 Married 1	rmed Forces?  ☐ Yes 2 No		**	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Black, White	
ours a	by	3 ☐ Widowed 4 ☐ Divorced Y	Yes, Give ear or Dates:	1	□Yes 24∑ No	Specify:			Specify: Wh:	ite
72 hc	etec	15. Decedent's Educatio (Specify only highest grade con		Give k	ent's Usual Occup and of work done	ation during most of wor d)	king	16b. Kind	d of Business/li	ndustry
filed within 72 hours after death with the Maryland Hygiene. Hygiene, wither than "natural"; or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	college (1-4or 5+)		echanic	1)		Λ,,,	comotiv	0
filed Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, Last)		- 11	CCHanic	18. Mother's Nan	ne (First, Middle			E
uld be Jenta rked tic ev	ToB	Charlie Ervin Smith				Ida Ma	e_E11io	tt		
2 sho and h is ma	•	19a. Informant's Name/Relationship (Type. F	Print) 19	b. Mailing	Address (Street	and Number or Ru	ıral Route Numl	ber, City or	Town, State, Zi	p Code)
l and fealth m 27		Bernice Smith - wife			Hartford ition (Name of	Road, Sa	alisbury Date		21801 ation - City or T	Town State
ages nt of h : If ite		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Remo	val from State cemet	ery, crem	atory or other plac	1				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Insperment of Health and Mental Hygiene. Insperment of Health and Mental Hygiene. Insperment of Health and Mental Hygiene. In marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Spring		L Memory  Name and Addre	Gds 1-9	ounds Fu		on, Mar	yland
Depariment Department		Malisa Leury	Hake			n Street				04
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death. Do	not ente	r the mode of dyir	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Pulmo Due to (or as a consequence	NA	RY	ZMBO.	LISM			Onset and Death
/ /Medical Examiner		resulting in death)								
- P	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence		47				-	
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Еха	resulting in death) Last	Due to (or as a consequence	of):						
ate be	Jical									
death certificate be e attending physicie of for use as the bu	Physician/Medica	IF FEMALE: 23c. II	yes, outcome pf pregnancy					20	ld. Data of dalis	
atten for us	cian	in the past 12 months?	Live birth 2 Fetal deat		Ectopic pregnancy Other <i>(specify)</i>	1		23	ld. Date of deliv Month	Day Year
t the c by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Unknown							
The law requires that the ate has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions contribu	ting to death but not resulting	in the un	derlying cause giv	en in Part I.		\		the cause of death?
require							10	Yes 2	No 3□ Pro	bably 4 ∐Unknown
2 88 2	Completed						24a. Was		prior to co	opsy findings available ompletion of cause of
		05.00					1□ Yes	2 No	death? 1 ☐ Yes	200
Attending Physician: r death. ector: After this certific. by the funeral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospi	tal: 1 Inpatient 2 ER/O	utpatient	3□ DOA Oth	er: 4 \(\sum_\) Nursing H	ith <i>(Ch</i> eck only ome 5□ Res		□Other (Spec	ifu)
g Phy ter this	-	27. Manner of Death 28		Time of Injury	28c. Injur Wor		28d. Describe			197
endin eath. or: Af he fur	atio	1 Natural 5 Pending investigation	(30.3.3.)			Yes 2□No				
or Att fter de Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	Be. Place of injury - At home, f building, etc. (Specify)	arm, stre	et, factory, office			(Street and wn, State)	Number or Rui	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Physicia	1: To the best of my knowledge	ge, death	occurred at the tir	ne, date and place	, and due to the	cause(s) a	and manner as	stated.
e Hos 124 h e Fun	Medical	(Check only 2 Medical Examiner:	On the basis of examination a							
To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens				signed (Month	
Q1		186	my	·	00	0584	10	1.	- 5 - 0	26
200		30. Name and address of person who comple	ted cause of death (Item 23a)	(Type, F	Print)		(T 0	4111	nun:	0 6 1 no 2180
)		CHULAM WAR	32 Registrar's Signature	147	KOWW	000	C1. 51	4215	BUK	1 KD 2180

07-00157

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ustice Stotler	R	- For State		f Maryland /		rtment of Hea tificate of Dea			Reg	No. 20	107	01378
Physicia Vledical Examin	n/	1. Decedent's Name (First,							Date of Death Month E anuary 6, 2	Day Yea		3. Time of Death 1320 hrs
Hedical Examin		Justice Calv				4b. City	Town, or Loca		andary 0, 2	4c. County of	of Death	
1		Johns Hopkins Ho					imore				Ta ala	
Funeral Director	:	5. Social Security Number 212-77-2032		7. Ag	e (In yrs. Ia	st birthday) If Ur Mon Yrs. 4		Under 24Hrs. 8 Hours Min.	8/16/2		9. Birth Foreign Cour	
any	_	Usual Residence of Deceder 10a. State 10b. Co			10c City,	Town or Location	<del></del>		-			10d. Inside City Limits
. ≜	ا ة	Maryland Was	hingto	on		Hagersto	wn					1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number				10f. Z	ip Code		10g	Citizen of Wh	nat Count	ry?
ith the 23a of notifi		13502 Spriggs		12. Was Decedent	Ever in II 9		21742	c Origin? ( Specif	fv Yes or No-	USA 14 Race	- Americ	an Indian, Black,
eath wi		1 X Never Married 2		Armed Forces?				xican, Puerto Ric			e, etc.	
after d	년 교	3 Widowed 4		Yes, Give Year or Dates:			2X No sp			Specify	Wh	
hours "natur	Ed -	15. Decedent's Education  Elementary/Secondary (		highest grade con College (1-4 or		16a. Decedent's Usu during most of w		NOT use retired)		6b. Kind of Bu	siness/In	dustry
5-0036 led within 72 hours after tygiene other than "natural", the Medical Examiner	Completed	0	, , , , ,	0		No	ne			None	е	
		17. Father's Name (First, M			•			lother's Name (Fi			)	
2127 ald be 1 Mental marke event		Christopher A				19b. Mailing Addre		Ashley I			n, State,	Zıp Code)
imore, MD 2121 Pages 1 and 2 should be fi nent of Health and Mentall fant: If item 27 is marked or other traumatic event,	-	Ashley Myers	s - Mot	ther		13502 Sp	riggs R	load, Hag				
rre, l s l and sf Healt If item		20a. Method of Disposition  1 X Burial 2 Crer	nation 3	Removal from St	1	Place of Disposition (National Place of Disposition (National Place of Plac		ry, D	ate	20c. Location -	· City or T	own, State
Page Page ment of tant:		4 Donation 5 Oth	er Specify:			se Hill Ce		1/11,				, Maryland
Balt permit Depart Impor		21 Signature of Funeral Se	rvice License				nd Address of F	n Blvd.		neral l		21740
Physician	$\dashv$	23a Part I. Enter the disea failure. List only one			the death.							Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final di	sease a.H	ead Injuries								Death
1		or condition resulting in de	h	ue to (or as a cons	equence of	f):						
	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Course or a pury that in the course of the cour	ause c.	ue to (or as a cons								
rted d ansit	Exa	events resulting in death)		ue to (or as a cons	equence of	f)						
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED		AMENDED								
760, ircate be g physic the bur	/Me	IF FEMALE: 23b. Was decedent pregna	nt in the	23c. If yes, outco	me of pregr		2 TE	Estania prognanci	,	23d Date of Month	f delivery Da	ay Year
x 68 h certif tending	sician/	past 12 months?		1 Live birth 4 Pregnant a	time of de	2 Fetal dea ath 5 Other (S		Ectopic pregnancy	,	Month	Di	ay rear
Division of Vital Records, P.O. Box 687 ral or Attending Physician: The law requires that the death certific ras after death.  **I Director** After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	Phys	1 Yes 2 No 9	Unknown	9 Unknown	h hut not so	aulting in the underly	en noune diver	n p Port I	23e Did tob	acco use contr	ribute to t	he cause of death?
of Vital Records, P.O. Bing Physician: The law requires that the dAfter this certificate has been signed by the tuneral director, page 2 should be detached	à	Part II. Other significant of	onations (	contributing to dear	n put not re	esuiting in the underly	ing cause giver	imrani.				ably 4 Unknown
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on of nding a th. r: Afte re funer	ion:	1 Natural 5	Pending	FOUND: Day,	Year)	FOUND:			ild abuse	w injury occur	eu	
visic r Atte ter dea irrector	ficat	2 Accident 3 Suicide 6	Investigation Could not be	28e Place of I	njury - At h	2330 hrs ome, farm, street, fact	ory, office build	ling, etc. 28	or Town, Sta		er or Rur	al Route Number, City
[ E S E E ]	Certification:	4 V Homicide	determined	(Specify) Si					502 Spriggs	Rd, Hagersto		
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Finiteral Director: After this certificate I completely filled in by the funeral director, page	Medical	Oricon orily	al Examiner:		amination a	ge, death occurred at ind/or investigation, in						
F 3 F 8	Me	29b. Signature and title of		<i>?</i>			29c License nu			29d. Date sign		th, Day, Year)
		Jash	17	e cef	Up		O.C.M.E	=. 		January 8,	2007	
641		30 Name and address of Tasha Greenberg		ompleted cause of ssistant Medic			n Street, Ba	Itimore, MD 2	21201			
	ate	31. Date filed (Month, Day		32 Registr	ar's Signati	ure	,					
Regis	trar	JAN	0 9 20	11 Stores	see A	T. Sparke		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 705 AM **Physician** 2007 Charles Reno SMITH January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🕅 F Maryland 83 1923 213-12-7655 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 No Hagerstown Director Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21742 Apt. 303 20014 Rosebank Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WW II within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🖾 No Specify. Saltimore, Maryland 21215-0036 Specify: white Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electric parts distrib. custodial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Elizabeth Harper Harry Edward Smith, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If Item 27 Is ny injury or other trau 15320 Hotts Lane, Sharpsburg, Md. 21782 Mary E. Hott - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 1/8/07 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22) Name and Address of Facility 21. Signature of Euneral Service License MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE MULTIORGAN **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner SEPSIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine PHELMONIA The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MYOLARDIAL INFARCTION 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CEREBROVAS CULAR ACCIDENT 24a. Was an perform 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 20 No 1 Inpatient 2 TER/Outpatient 3□ DOA 2 27. Manyer of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01-04-07 Madran Hubbly D62562 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Md 21740 251 15H-5+1 Last 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Amend #25, perMD, g867, 5/19/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day O2 Year 7 **Physician** : 18 PM George T. Shade /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under ivista enter harles er 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 26, 1947 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□F Months Days Hours 217-44-9789 59 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, he Medical Examiner must be notified at Completed by Funeral Director Md. Charles Newburg 1 □Yes 2√No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11955 Edgehill Rd. 20664-0094 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ould be filed within 72 hours after Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Md. Dept. of Trans. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatte every once. Brooks A. Shade Elizabeth Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie L. Shade, wife 15100 Ridge Rd. King George, Va. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State Jan.8, Shiloh Comm.Ch.Cem. Shiloh, Md. 4 Donation 5 Dother (Specify) 2007 22. Name and Address of Facility Cedell Brooks 21. Signature of Europeal Service Funeral Home P.O.Box 11 Port Royal, Va. -MO 1325 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one capte on each line. Approximate Interval Between Onset and Death Tue to (or as a consequence Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician and Due to (or as a consequence of): Physician/Medical Box ( IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) Ö 9 Unknown ģ <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 🔲 Inpatient 2 DENOutpatient 3 DOA Certification: To this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a Type Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. Date signed (Month, Day, Year)

State Registrar mpleted cause of death (Item 23a) (Type, Print

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Alexander Main Smith 07 07 4:34 A 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS Date of Birth (Month, Day, Year) November 18, 1929 9. Birthplace (State or Foreign County) and 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number **Funeral** 1X M 2□ F 77 212-24-0660 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Lonaconing Director Maryland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21539 17003 Lower Georges Creek Road S.W. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paper Mill 0 Maintenance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Main John Stafford Smith ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17003 Lower Georges Creek Road S.W., Lonaconing, Maryland 21539 Ann Smith - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 11. 1 Burial 2 □ Cremation 3 □ Removal from State Frostburg, Maryland Frostburg Memorial Park 2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street, Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): how **Physician** /Medical **Examiner** Esqueritary lite comment, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No page Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕍 No 2 SER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury the Hospital or Attending 1 🗹 Natural 5 ☐ Pending investigation 1 Yes 2 No nours after death. neral Director: A' y filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Douglas Ave.

MD. 20 Peulin homas

31. Date filed (Month, Day, Year) JAN

29b. Signature and title of contifier

32. Registrar's Signature 2007

Long conjug.

State

Registrar

			1 - For State Registrar	State of	Maryland		artment of rtificate of	Health and Death	Mental H	lygien Reg. N	Z U U .	01382
			1. Decedent's Name (First, Middle,	Last)					2. Date of	Death		3. Time of Death
	Physici		Shirley Ann	seve	re				Janua Janua	Da Irv (	6 200	
	/Medio Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location of Dea			. County of D	
			Dennett Road Ma	nor Nursi	ng Home	2	0akla	and			Garret	t
	Funeral				Age (In yrs. la		If Under 1 Yea	If Under 24 Hrs		Birth	Q	Birthplace (State or Foreign
	Director		232-54-2506	1 ☐ M 2 💢 F	69	Yrs.	Months Days	Hours Min	Sept.	Day, Year		Country) Maryland
	D		Usual Residence of Decedent						тосре.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ialyland
	how		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Ma B-f-s	ioi	MD Garre	ett	Mtn	. Lak	e Park					tX Yes 2 □ No
	n th	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of Wha	t Country?
	h wii	<u>a</u>	506 K. Street				2155	0		Uı	nited	States
	eep EE	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.		Was Decedent of	Hispanic Origin? (	Specify Yes or	No-		American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28s-f show sayl follury or other traumatic avent, the Medical Examinar must be notified at ADES.	by Fu	1 Never Mamed 2 Marrie 3 ☑ Widowed 4 Divorced		₩No		1 Yes, specify Cu 1 ☐ Yes 2X No	ban, Mexican, Puel Specify:	no Hican, etc.)		Specify:	White, etc. White
Ö	2 hou	Ped	15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation		16b. H	Kind of Busine	
15	in 7	Completed	(Specify only highest	grade completed)		(Give	kind of work done DO NOT use retir	during most of wo	orking			,
12	iene iene	E	Elementary/Secondary (0-12) 12	College (1-4	or 5+)	Ma	nager			Re	estaur	ant
	Hyg Hyg ent,	0	17. Father's Name (First, Middle, La	ist)				18. Mother's Na	me (First, Midd	dle, Maidei	n Sumame)	
Maryland	d be ental ked c sv	To B	Lester	Culp				Ruby		Цал	rvey	
2	Should Mark	-	19a. Informant's Name/Relationship			19b. Mailir	na Address (Stree	it and Number or R	ural Route Nur			te. Zin Code)
S	trau		Jeffrey Hinebau	ach Son	1			board Rd				
Đ,	Hea Hea tem		20a. Method of Disposition	ign, bon	20b. Pla	ce of Dispo	sition (Name of		Date	-		or Town, State
0	nt of nt of t: If It		tX☐ Burial 2 ☐ Cremation 3		ate cer	netery, crer	natory or other pl	· 1	10.107			
Baltimore,	rtan njun		4 □ Donation 5 □ Other (Special Service Line)		Gar			Gdns. 1			kland,	
Ba	Depermine Deperm		Lound A-	Burdo	Ŕ	22	. Name and Addi	В				ral Home MD 21550
			23a. Part1. Enter the disease, or conscious, or heart failure. List of	omplications that cau	sed the death.	Do not ent						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1	1	. (	11.5	10 - IM	r.			Onset and Death
	/Medical		resulting in death)	a. Due to (or	as a conseque		JUN 21	nome				year
	Examiner		100 100 100 100 100 100 100 100 100 100		·	,						•
		e	Sequentially list conditions,	b. Dias to (or	as a conseque	ince-of)-						
	d d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ć.	icate be executed physician end s the burial-transit	Examiner	resulting in death) Last	Due to (or	as a conseque	nce of);						
68760,	e be sicia e bur	dlcai		d								
.89	flicat g phy as the			0.								
Вох	eath certificate be executed attending physician end for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. Date of	delivery
ă	atter	clar	in the past 12 months?		h 2 ☐ Fetal on nt at time of dea		Ectopic pregnand Other (specify)	су			Month	Day Year
P.O.	the d	ysi	1 □ Yes 2 <b>≥</b> No 9 □ Unknown	9☐ Unknow		02	Giner (speeny)			-		
	thet the de ned by the a	4	Part II. Other significant condition	s contributing to deal	th but not result	ing in the u	nderiving cause o	iven in Part I.	23e. Di	d tobacco	use contribut	te to the cause of death?
Records,	8 6 8	d by					, , , , , , ,			∐Yes 2		Probably 4 Unknown
Ö	w requir been si should	Completed										
Şe C	e law	du								topsy	prior	e autopsy findings available to completion of cause of
=	: The l	ပိ			_				1 ☐ Yes	rformed?	deat	n? Yes 2□ No
Zit.	ysician: Th iis certificete director, peç	Be	25. Was case referred to medical examiner?	Han-ital				26. Place of De	_			
of Vital	di ≅. ≼	မှ	1 ☐ Yes 2 € No		atient 2 E		IL 3 DOA		Home 5□ Re			Specify)
	aling F	ü	27. Manner of Death  Death  S☐ Pending	28a. Date of (Month,	Day Year) 2	28b. Time of Injury	W		28d. Describ	e how inju	iry occurred	
Sio	Attending or death. ector; After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	7.4			M 1[	]Yes 2 □No				
Division	ter d lirect	Certification:	4 Homicide determin	ed 28e. Place of	Injury - At hom , etc. (Specify)	ne, farm, str	eet, factory, office	1	28f. Location City or	n (Street a Town, Stat	nd Number o e)	r Rural Route Number,
	ral b											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)  12 Certifying 2 Medical Ex	Physician: To the be caminer: On the bas and manner	is of examination	ledge, death on and/or in	n occurred at the vestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the tim	ne cause(s e, date an	s) and manne od place, and	r as stated. due to the cause(s)
	of the contract of the contrac	Me	29b. Signature and title of certifier	^			29c. Licer	ise number		29d. Da	ate signed (M	onth, Day, Year)
	3		> 60V				7706	15/		1	10%	7
	9		30. Name and address of person w	ho completed saus-	of death /lear of	(32) /7:	H26	154			18/0	F
								rland M	21550			
	Sta	10	Dr. Daniel Mi 31. Date filed (Month, Day, Year)		ictraric Signatu			kland, MD	21330			
	Registr				atherica A	b A	backs					

		For State Registrar		State	of Mary	land / Dep <i>Ce</i>	artmer e <i>rtificat</i>				lental Hy	/gier Reg. M		<i>j</i> 1	01303
		Decedent's Name (Fig. 1)	irst, Middle,	Last)							2. Date of D	eath			3. Time of Death
Physici		ORVAL	Ţ	VARD	STALE	Y, SR					Month Januar		Day 3 , 200	Year	11:30 A M
/Medic Examin		4a. Facility Name (If not	institution,	give street and r				Town, or	Location	of Death	Januar		4c. County		11.50 11
LXamin	C1	705 Fairy		Ave.				eder					_	deri	o.le
Funeral		5. Social Security Numb		6. Sex	7. Age (In	yrs. last birthday		1 Year		24 Hrs.	8. Date of Bi	rth	FLE		
Director		212-24-7455		1 M 2 □ F		76 Yrs.	Months	Days	Hours	Min.	June 2	av. Yea	930	Mary	nlace (State or Foreign ntry) 1 and
		Usual Residence of Dec					<u></u>				Julie 2	0,1	230	rial y	Tanu
/lanc		10a. State 10i	b. County		100	c. City, Town or I	ocation.							1	0d. Inside City Limits
Mar Mar	ţ	Maryland	Fre	ederick		Frede	rick								1 XYes 2 No
28°	e S	10e. Street and Number				1100	10f. Zig	Code				10g. (	Citizen of W	/hat Cour	ntry?
38 O	۵	705 Fa	airvie	w Ave.				2170	1			Un	ited	Sta	tec
permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturel", or iteme 23a or 28e-f ehow amy injury or other traumatic event, the Medical Examinating Incitited at ODGe.	Funeral Director	11. Marital Status			ecedent Ever	in U.S. 13	. Was Dece			igin? (Spe	ecity Yes or N		,		an Indian,
fer the second	F	1 Never Married	2 Marrie		Forces? s 2 ☐ No		If Yes, spe	cify Cuba	n, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	_		k, White,	
o'.'s		3 ☐ Widowed 4 ☐	21	If Yes		52-56	1 🗆 Yes	2\XXNo	Specify:				Specify	: Wł	nite
2 hor	Completed by	15.	Decedent's	s Education			edent's Usu	al Occup	ation			16b.	Kind of Bu	siness/în	dustry
n n	ple			grade complete		(Giv	e kind of wo DO NOT u	rk done	durina mos	t of work	ng				,
the ien	E	Elementary/Secondar	ry (0-12)		(1-4or 5+) 3	Sup	ervis	r				E1	ectro	nics	Mfgr.
Hyg Hyg other		17. Father's Name (First	t, Middle, L	-					18. Mothe	er's Name	(First, Middle				111.61.
d bear and b	o Be	Charle		н.	Sta	1 0 17			Tomo			C.			
houi d Me mari	은	19a. Informant's Name/			sta		ina Address	/Straat	Lenc		al Route Numb		tone	State Tie	Codel
d 2 s th ar 7 ie trau															CODE
ther		Gloria G. S		y / wire		0b. Place of Disp			Ave.		ederick	-	D 2 Location -	1701	Charles Charles
0 1 2 0 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 🔀 Burial 2 🗆 Cr	remation			cemetery, cr	matory or	ther plac				200.	Location -	City of 10	wn, State
tant fury		4 Donation 5				Mount 01					/2007				aryland
permit Depar impor any in		21. Signature of Funera	I Service L	icensee	//	, ;	2. Name a	nd Addres	ss of Facili	<sup>ty</sup> Sta	uffer	Fune	eral 1	Home	
₹0.5 € d		Saym	and	Bell	Riso						ke/ Fr		rick,	MD	21702
		23a. Part1. Foler the di short, or heart fai	isease, o d ilure. List o	complications that	t caused the each line.	death. Do not e	nter the mod	le of dyin	g, such as	cardiac o	or respiratory a	arrest,			Approximate Interval Between
Physician	J. 1	Immedia Cause (Fina disease or condition		_		e Parki	ngon		Demen	+ 1 -					Onset and Death
/Medical		resulting in death)	- 1			nsequence of):	.115011		Demen	ıııa					
Examiner				10		s type 1									
	e	Sequentially list condition if any, leading to immediate	ons, diate			nsequence of):									
uted ansit	ᆵ	if any, leading to immed cause. Enter Underlyin Cause (Disease or injur	9 y	A:	trial :	Fibrilla	tion								
eath certificate be executed ettending physicien and for use as the burial-transit	Examin	that initiated events resulting in death) Last		U		nsequence of):									
sicie buri				l .											
phy:	edical			d											
ding		IF FEMALE:		23c If yes o	outcome of pr	ennancy									
etter for u	lan	23b. Was decedent pre in the past 12 mon		1 □Live	birth 2	Fetal death 3	□Ectopic p						23d. Date Mor		ny Day Year
the d	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	)	9 Uni		UI UBA(II 5	Other (sp	өспу)							
het ti od by detec		Part II. Other significan	t condition	s contributing to	death but no	t resulting in the	underhing	222	on in Rest I		220 Did	tobaco	n una contr	ibuta ta t	ne cause of death?
signe be	þ				GOGUI DULIIG	t resulting in the	underlying t	ause give	eri ili rali (i.	•					
neeu nonic	ted	gait di	sorde	Γ				-			10	Yes	2) No	3   Prob	ably 4 Unknown
law asb	Completed										24a. Was				psy findings available npletion of cause of
The ste h page	ĕ											ormed?	ď	eath?	2 No
ien: rtifica	0	25. Was case reterred t	o medical						26. Place	of Death	(Check only				
ysic is ce direc	To B	examiner? 1 ☐ Yes 2 🔯 No		Hospital:	] Inpatient	2 ER/Outpatie	nt 3∏ D0	Othe			me 5K Res		6 □Othe	r (Snecih	41
g Ph er th eral		27. Manner of Death		28a. Dai	e of fnjury	28b. Time		8c. Injun		7	28d. Describe				,
oth. Sth. Str. Aft	at 6	1 XNatural 5 2 ☐ Accident	<ul><li>Pending investiga</li></ul>		onth, Day Yea	ar) Injury	м		<br Yes 2 □	No					
Attended on the sy the	ffca	3 Suicide 6	Could no	ned   289. Pla	ce of Injury -	At home, farm, s	treet, factor	, office		1	28f. Location (	Street	and Numbe	or Or Rura	I Route Number.
effe Dir	Certification:	4 Homicide		bui	lding, etc. (S	oecity)					City or To	wn, Sta	ite)		
spits nours ners		29a. Certifier 1	Certifying	Physician: To t	he best of my	knowledge, dea	th occurred	at the tim	ne. date an	nd place. a	and due to the	Cause	(s) and mai	nner as si	abol
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effecteeth.  To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	edical	(Check only 2 one)	Medical E	xaminer: On the	basis of exa	mination and/or i	nvestigation	, in my of	pinion, dea	th occurr	ed at the time,	date a	nd place, a	nd due to	the cause(s)
o thing of the complete of the	Me	29b. Signature and tille	Sycertifier	1	.//1		1 29	. License	number			29d. D	ate signed	(Month,	Day, Year)
- ≤ - ō		1000	In	Koi	U1	NMI	/	D 54	4749				nuary		
		2000	UVU	,	/	1	D: S							٠,	
)		30. Name and address of						**	. –						_
,		Allen R	eilly	, MD ,	SOI TO	oll Hous	e Ave	. D-	1, Fr	eder	ick, Ma	ary1	and	2170	1

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 8 2007

Sparks

2. Date of Death Month

Month Day Year January 11, 2007

3. Time of Death

2:28 A.M

F	Phy	/si	cia	n
	/N	lec	lic	al
	Ex	am	ine	er

1. Decedent's Name (First, Middle, Last)

Harriett

Marian

	Examin	er	<ol> <li>Facility Name (If not institution, giv</li> </ol>	e street and number)		4b. City, Town, or	r Location of Death		4c. County	or Death	
			St. Mary's Nursi	ng Center		Leonardt	own		St. M	Mary's	
aghin or '''	Funeral	-	5. Social Security Number 6. S		(In yrs. last birthd		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	h v Year)	9. Birthplac	ce (State or Foreign
	Director		039-12-8342	I M 2 XF	83 Yrs	Months Days	Hours With.	08/22/		Georgi	
32. m	Director	1	Usual Residence of Decedent		03			00/22/	1723	000161	
	pug w		10a. State 10b. County		10c. City, Town or	r Location				100	d. Inside City Limits
	anylis sho id ad	<u> </u>			** 11						1 ☐ Yes 2 XNo
	e M	Ct	Maryland St. Mary	'S	Ho11ywoo				10 000 11	***	
	h th	jre	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/vnat Country	y?
	3a c	Funeral Directo	44875 Smiths Nurs	ery Road		20636			U.S.A.		
	ns 2	Jer.	11, Marital Status	12. Was Decedent Ev	ver in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Sp	ecify Yes or No	14. Rac	ce - American	,
	ter o	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣 No	0			nican, etc.)		ck, White, etc	C.
ဗ္ဗ	rs af	b	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify	y: Whit	e
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	찟	15. Decedent's E	ducation	16a. De	ecedent's Usual Occup	pation		16b. Kind of B		
က်	"na"	ete	(Specify only highest gr	ade completed)	(6	live kind of work done for DO NOT use retired	during most of work	ing			
2	ne. han e Me	ם	Elementary/Secondary (0-12)	College (1-4or 5+	•)	emaker	/		Own Hor	m o	
N	ed w ygie ier t	Completed	10		HOME	elliake I	18. Mother's Name	o /Eiret Middle			
פ	al H loth	Be	17. Father's Name (First, Middle, Last	)			10. Mother's Mann	e (i iisi, iviidale,	Maideri Garnan	no)	
<u></u>	Ald the state of t	ဥ	Harry Emanuel Dou	glas			Annie Mae	e McKel	ven		
3	2 should be filed w and Mental Hygie is marked other t 'aumatic event, th	-	19a. Informant's Name/Relationship	Type. Print)	19b. N	lailing Address (Street	and Number or Rur	al Route Numb	er, City or Town,	, State, Zip C	Code)
Š	id 2 Ith a 27 is trau		Tami M. Stickell/	Daughter	9663	2 Ridgeview	J Drive. (	Wines.	Marylar	nd 20	736
	1 and Health em 27 ther t	11 3	20a. Method of Disposition	Daughter	20b. Place of D	isposition (Name of		Date	20c. Location		
Ö	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐			crematory or other pla	1	.			
Ξ	Pa men ant: ury		4 □ Donation 5 □ Other (Speci	(y)	Brinsfi	eld-Echols	Cre: 01/1:	2/2007	Charlot	cte Ha	11, MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Lice	nsee	S	22. Name and Addre	ess of Facility Bri	nsfield	Funera	1 Home	2
m	9 9 E E 9		Kyle S. Simons			22955 Holl					20650
9	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		23a. Part1. Enter the disease, or con shock, or heart failure. List only	iplications that caused t	the death. Do not	enter the mode of dyli	ng, such as cardiac	or respiratory a	rrest,	í	Approximate Interval Between
			Immediate Cause (Final			was Lano	India	at.			Onset and Death
	Physician /Medical		disease or condition resulting in death)	d		) water	70414	, , , , , , , , , , , , , , , , , , , ,		_	
	Examiner				consequence of)	to the	NNP.				
31	- pri		Sequentially list conditions	b		renter the mode of dyll real forms  to the  demo	, , , , ,				
	p #	Examiner	if any, leading to immediate cause. Enter Underlying		consequence of)		1-				
	oute	Ē	that initiated events	c. Adv	ance	deine	J4100				
Ć.	exe in ar	Ä	resulting in death) Last	Due to (or as a	consequence of)	:					
P.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical		_d							
ထ္ထ	ficat phy s th	edi	1								
×	certi ding se a	Ž	IF FEMALE:	23c. If yes, outcome p	of pregnancy				23d. Da	ate of deliver	v
a	ath utten or u	ä	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at t		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	EY		M	onth E	Day Year
<u>.</u>	e de	Sic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	ume or deam	J _ Other (specify) _					
<u>о</u>	at th by t	بح			4 4 1 41	and the state of t	ion in Dort I	23a Did i	lahacaa usa can	stributa to the	e cause of death?
ď.		by	Part II. Other significant conditions	contributing to death bu	t not resulting in ti	ne underlying cause give		111			% _c
Ď	The law requires ate has been signate age 2 should be	D D						1	Yes 2 No	3 ∐ Proba	bly 4 Unknown
Record	w re	Completed						24a. Was		. Were autop	sy findings available
Re	e la has	문							ormed2	death?	pletion of cause of
=		ပိ						1□ Yes		1 □ Yes 🦂	2 □ No
ij	s <b>ician:</b> Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Magnitali		Out	26. Place of Dea				
or Vital	gi is	ဥ	1 Yes 2 No	Hospital: 1  Inpatier		atient 3 DOA			idence 6 Ot		)
0			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day			iry at irk?	28d. Describe	how injury occu	rred	
<u>ō</u>	ndir th.	ije.	2 Accident investigation	on .	.	M 1	]Yes 2 ☐ No				
/is	Attending r death. ector: After by the fune	ţi	3 ☐ Suicide 6 ☐ Could not a determined	2   Zoe, Flace of Inju	ry - At home, farm	n, street, factory, office			Street and Num wn, State)	ber or Rural	Route Number,
Division	afte Dir	Certification:	4   Hornicide	building, etc	. (Эреспу)			ony or ro	m, oldio,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	0	29a. Certifier 1 Certifying F	Physician: To the best of	of my knowledge,	death occurred at the t	time, date and place	, and due to the	cause(s) and m	nanner as sta	ated.
	Hos 24 ho Fur stely	ledical	(Check only 2 Medical Exa	aminer: On the basis of and manner sta	examination and/	or investigation, in my	opinion, death occu	rred at the time	, date and place	, and due to	the cause(s)
	thin ; the the	Med	29b. Signature and title of certifier	and mainter sta		29c. Licen	se number		29d. Date sign	ed (Month, E	Day, Year)
	P N O	=		212		T	4706	6	-	2.0	
	24		) ASh	are			, , , ,				Ę
	()(		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)					
	* \	1	Avani D. Shah, M	i.D., 22650	Cedar La	ane Court,	Leonardt	own, Ma	ryland	20650	
	St	ate	31. Date filed (Month, Day, Year)		ar's Signature						
	Donie		JANIZ	ZUU/ /	. K	directly a					

			For State Registrar		-	ertificate	of Death	R	eg. No.	
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Dea Month	Day Yea	
	/Media	al	Rosemary Anne	Smith		4h City Tou	m, or Location of Dea	January	2 2007 4c. County of De	
	Examin	er	4a. Facility Name (If not institution, give		Fand Dlage		Frederick	UI.		erick
	Funcial	577	2100B Whittier Dr 5. Social Security Number 6. Sec		FORG Place	y) If Under 1 Y	ear If Under 24 Hrs	8. Date of Birth	9 5	Birthplace (State or Foreign
	Funeral Director			M 2 ☐ F	85 Yrs.	Months D	ays Hours Min	Jan. 15	, 1921 I	ndiana
	land ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Man	tor	Maryland Freder	ick		Free	lerick			1 XYes 2 No
	n the	irec	10e. Street and Number			10f. Zip Co	de		0g. Citizen of What	Country?
	th wi	ai	2100B Whittier	Drive			21702		U.S.	Α
	r dea	nei	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	B. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.
ווומו לומוות בובוס סססס	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Madical Expedimentants he published at	d by Funeral Director	1 ☐ Never Married 2 ☐ Married  3 ☑ Wildowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐	No Specify:		Specify:	White
	72 h	etec	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a. De (Gi	edent's Usual O	ccupation one during most of wo atired)	orking	16b. Kind of Busines	ss/Industry
4	within ne. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) life				-1.45	h am a
4	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)			homemal	T	me (First, Middle,		home
3	d be antal	o Be	Leo G. Driscoll				Nina	Franzman		
	should tund Ment	P.	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	iling Address (S	reet and Number or R			e, Zip Code)
	nd 2 alth a 27 is r trev		Sharon L. Wallick/	daughter	. 393	6 South	view Ct.	Jefferso	n, MD 217	55
5	ss 1 and 2 of Health Itam 27 i		20a. Method of Disposition		20b. Place of Dis		of	Date	20c. Location - City	or Town, State
	Pages nent of int: If Its iry or o		1 ØBurial 2 ☐ Cremation 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		•	dens 1/5	/2007	Frederick	. MD
Dalilliole,	permit. Pages Depertment of I Important: If Its eny injury or o		21. Signature of Funeral Service Licens	Z/an De	Per	22. Name and A	ddress of FacilityHam Main St.	rtzler Fu		e
	_	$\vdash$	23a. Part1. Enter the disease, or compl	ications that caused	the death. Do not a					Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each II	ne.					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	C_LU	ng CF	ncer		6month
	Examiner		a salah da salah da salah salah salah salah salah salah salah salah salah salah salah salah salah salah salah s							
-	n =	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	ocute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	3						
Š	ifficate be executed g physicien and as the burial-transit	ŭ	resulting in deathy cast	Due to (or as	a consequence of):					
	physic the t	edical		d		-	<del></del>			
			IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date of d	delivery
	attending	Physician/M	in the past 12 menths?		2 Fetal death	B □Ectopic pregr			Month Month	Day Year
	the d	ıysı	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown					N	//A
	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	by PI	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying caus	e given in Part I.	23e. Did to	bacco use contribu	to the cause of death?
necolus,	quire an sig uld b	Pa Pa	anemia					1 □ Y	es 2□No 3□	Probably 4 Unknown
	s bee	Completed						24a. Was a	ın 24b. Were	autopsy findings available to completion of cause of
-	The lay	E						autop: perfor 1 \( \text{Yes}	med? death	es 2 No
		Bec	25. Was case referred to medical				26. Place of De	ath (Check only or	-	
5	Physicien: r this certific ral director,	To E	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1  Inpatie	ent 2 ER/Outpat	ient 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	ence 6 Other (S	pecify) living
=	fler ti		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time uy Year) 1njur	/	Injury at Work?	28d. Describe h	ow injury occurred	Facility
	Attending r death. ector: After by the fune	cati	2 Accident investigation		1	М	1 ☐ Yes 2 ☐ No			
	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, c. <i>(Specify)</i>	street, factory, or	fice	28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely illed in by the funeral director.	edical (			f examination and/or		ne time, date and plac my opinion, death occ			
	To the within To the comple	Me	29b. Signature and title of certifier			29c. L	cense number	2	29d. Date signed (Mo	onth, Day, Year)
	1.		) And	0	101-1	200	D5/64	3	1/4/07	•
1	WH.		30. Name and address of person who co	ompleted cause of c	death (Item 23a) (Typ	e, Print)			11	***
	6		65 c Thoma	5. Tha	nson Do	Fre	D5164	mo o	11702	
	Sta		31. Date filed (Month, Day, Year)	32 Alegistr	ar's Signature	1				
	Regist	ar	JAN 0 5 201	1 Daniel	C 15 1	marke				

			1_ For State	State of	Marylan	-	artment <i>rtificate</i>			nd M	ental Hy			is over		0.0
	4		Registrar  1. Decedent's Name (First, Middle,	Last)		00	tineate	01 00	cairi		2. Date of D	Reg. Ne	·20	1	3. Time of D	eath
ı	Physici /Medio		Sheila Sastri								Januar	D	<sup>ay</sup> 2007	/ear	2:25	Ам
	Examir	er	4a. Facility Name (If not institution,	•	,		4b. City, To		ocation of	f Death			c. County of			
			Shady Grove Adv  5. Social Security Number		*	last hirthday	Rockv:		f Under 2	A Hre	8. Date of Bi		ontgo			
0	Funeral Director		619-54-4461	1 M 2 XF 7.		last birthday) 81 Yrs.			Hours	Min	Month, D	ay, Year 19	25	Coun Indi	lace (State or i try) .a	-oreign i
	pu ,		Usual Residence of Decedent		100 0	h. Tourney La	agtion								0.1 1- 11- 01-	Limite
	aryla shov	'n	10a. State 10b. County		_	ty, Town or Lo								'	0d. Inside City 1 ☐ Yes 2	
	the M 28a-f notifie	ect	MD Montgo  10e. Street and Number	mery	Geri	mantow	1 10f. Zip C	'odo				10g C	itizen of Wh	at Cour		
	with 3a or 1 be r	Funeral Director	13418 Rising Su	n Lane			2087					USA		iat oour	iu y i	
	ms 2:	nera	11. Marital Status	12. Was Decede	ent Ever in U	l.S. 13.	Was Decede If Yes, specif		anic Orig	jin? (Spe	cify Yes or N		14. Race			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Force ad 1 Tes 2 If Yes, Give Year or Date	<b>X</b> No		If Yes, specif 1 ☐ Yes 2Î		Mexican, Specify:	, Puerto F	Rican, etc.)			White,	<sub>etc.</sub> Indian	
21215-0036	2 hou atura cal E	Completed by	15. Decedent	s Education		16a. Dece	dent's Usual	Occupation	on			16b. I	Kind of Busi			
215	hin 7	ple	(Specify only highest Elementary/Secondary (0-12)	college (1-4	or 5+)	(Give life.	kind of work DO NOT use	done dur retired)	ing most	of workin	ng					
	er the	5		4		Homema	aker						Home			
Maryland	d 2 should be filed within 7 th and Mental Hygiene. 77 is marked other than "r traumatic event, the Med	Be	17. Father's Name (First, Middle, L	.ast)							(First, Middle	e, Maide	n Surname,	)		
χ	ould Men arke	၉	Chiranjiv Lal						wa1a							
Mar	d 2 sh h and 7 is n traun		19a. Informant's Name/Relationsh				ng Address (					-			,	
	1 and Health em 27 Ither tr		Srinivas Chandr 20a. Method of Disposition	aseknar/sc	20b. F	Place of Dispo	B Risin	of	ın La		erman		ocation - C			
nor	Pages nent of 1 ant: If Ite ary or or		1 ☐ Burial 2 🖺 Cremation		ate	cemetery, cre	-							-		
Baltimore,	artme ortan injur		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I,		Che	esapeal	<u>ke Crei</u> 2 Name and Ding Ho	nato: Address,	fy ; (	)1/03	3/0/	Вет	tsvil	<u>г</u> е,	MD 701	
B	permit. Departr Importa any inje		1 Bene 1 t	Holls	∠ MO.										. 784 . MD 21	1020
			23a. Part1. Enter the dis e, or o shock, or heart failure. List o	complications that cau	sed the deat	th. Do not en	ter the mode	of dying,	such as c	cardiac o	respiratory	arrest,	arksv	1110	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition											3	Onset and De	ath
1	/Medical		resulting in death)	a. <u>Conges</u> Due to (or	as a consec		dilui	=						1		
	Examiner		Sequentially list conditions	Pneumo										3	days	_
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a conseq	quence of):										
	xecut and I-tran	хаш	that initiated events resulting in death) Last	c	as a conseq	uence of):								-		
8760,	death certificate be executed e attending physician and d for use as the burfal-transit	dical E														
687	ficate physis the	edic		d												
Box	n certi	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregn	ancy	Je						23d. Date	of delive	ery	
		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No		h 2□Feta nt at time of c		□Ectopic preg □ Other (spec		-1				Mont	h	Day Ye	ar
P.0	at the by th	hys	9□Unknown													
	es gu	þ	Part II. Other significant condition	ns contributing to deat	th but not res	sulting in the u	nderlying cau	ıse given i	in Part I.				37		e cause of dea	
Records,	w requir been si should	Completed	3									Yes 2			ably 4 □Un	
Sec	hysician: The law his certificate has b I director, page 2 sl	nple								_	24a. Was	DSV	24b. We	ere auto	psy findings av npletion of cau	ailable se of
a F											1□ Yes	ormed? 2XIN	o 1 [	ath? ]Yes	2□No	
Vital	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:		15000		Other			(Check only					
9	Phys r this eral dir	2	1 ☐ Yes 2 X No  27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time o		. Injury at Work?	_		ne 5 Res				/)	
on	Attending r death. ector: After by the funer	tiol	1 X Natural 5 ☐ Pending 2 ☐ Accident Investiga		Day Year)	Injury	М		s 2 N				,			
Division or	Atter	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and   28e. Place of	injury - At h	ome, farm, str	eet, factory,	office		2	8f. Location (	(Street a	nd Number	or Rura	l Route Numbe	er,
Ö	tal or s after al Dir ed in b	Cert		Boilding	, etc. (Opecin	· <b>y</b> /					City of 10	wii, Siai	e)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)  1 Certifying 2 Medical E	<b>Physiclan:</b> To the be <b>Examiner:</b> On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred at vestigation, i	the time, n my opin	date and ion, deat	d place, a th occurre	nd due to the	e cause(: , date ar	s) and mani nd place, an	ner as st d due to	ated. the cause(s)	
	To the within To the COMP.	Me	29b. Signature and title of certifier	1			29c. l	License n	umber			29d. Da	ate signed (	Month,	Day, Year)	
			Loan	tu	m	0	De	60557	7			Jan	uary :	2, 2	007	
1	3)		30. Name and address of person v					1 4	. 1 7	MT	20050					
			Leo Shue, M.D.  31. Date filed (Month, Day, Year)		al Cen		rive Ro	OCKVI	rite,	, MD	20850					
	Sta Registi	_	JAN 0 3	2007	fisher s	K A	reck									

Registrar

State

medical center

Drive

Rockville MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 05 2007

tev

9901

32. Registrar's Signature

		1	For Amend Item 7 per State Registrar	aten f M84 182/	2 <b>8787</b> Cer	dment tificate	of He	ealth a	and Me	ental Hy	giene	07	0 388
			Decedent's Name (First, Middle, Last)							<ol><li>Date of Dea</li></ol>	ath		3. Time of Death
1	Physicia	an	Harrison Marley Thra	sher Sr.						Month January	Day 10, 2	Year 2007	5:10 P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street			4b. City, 1	Γown, or	Location o				nty of Deatl	
	LXumm		Oakland Nursing & Re	habilitatior	ı	0ak	Land				Garı		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da	v. Year)	Co	hplace (State or Foreign untry)
	Director		212-12-8837	89	Yrs.				]	Feb. 1,	1917	Maı	cyland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Lo	cation							10d. Inside City Limits
	Mary f ehc	ğ	MD Garrett	Oa	akland	i							1 May Yes 2 □ No
	r 28e	Director	10e. Street and Number			10f. Zip	Code				10g. Citizen	of What Co	untry?
	h with	a D	706 E. Alder Street				550				United		
	ens ens	Funeral		as Decedent Ever in U.S. med Forces?	13. V	Vas Deced f Yes, spec	ent of Hi	spanic Ori n, Mexicar	igin? (Spec n, Puerto P	cify Yes or No Rican, etc.)	- 14. F	Race - Ame Black, White	rican Indian, e, etc.
36	or it	by Fu	37If	☐ Yes 2 <b>∭</b> No Yes, Give ear or Dates:	1	I□Yes 2	2XNo	Specify:			Spe	city: Wh:	i t o
Ö	be filed within 72 hours after death with the Maryland nat Hygiene. Id other then "natural", or items 23a or 28e-f ehow other then "natural", or items 23a or 28e-f ehow event, the Medical Examinat must be notified at	ed b	15. Decedent's Education		16a. Deced	lent's Usua	I Occupa	ition			16b. Kind o		
7	in 72 n "ne Nedis	piet	(Specify only highest grade com	pleted) ollege (1-4or 5+)	(Give life. L	kind of wor DO NOT us	rk done d se retired,	lu <i>ring m</i> os )	t of workin	1g			
212	e filed within at Hygiene. I other then "vent, the Me	Completed	12	511 <b>6</b> 96 (1 461 51)	P1um	nber 8	E16					ructi	Lon
b	be filed ital Hygi od other event, I	Bec	17. Father's Name (First, Middle, Last)							(First, Middle,		name)	
yla	2 should be and Mental ie marked of aumatic ev	၉	John Robert Letrobe							rover N			7'- 0-1-)
Baltimore, Maryland 21215-0036	s 1 end 2 should i Health and Men item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Type, P			-				Route Numbe			
e, P	1 end 2 Health tem 27 i		Robert W. Thrasher,	20b. Plac	ce of Dispo	sition (Nan	ne of			eer Par			Town, State
קסר	ages nt of i. if it		1 ☐ Burial 2 XCremation 3 ☐ Remov	al from State	netery, cren perlai			1	1/1/4	/07	Cumbe	rland	MD
표	permit. Pages 1 en Department of Heal importent: if item 2 eny injury or other once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	Cum						dock-Dı			
Ba	Depa impo eny i		Kather die Mu	Rither									MD 21550
F			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	use on each line.			e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Brong lance	MIC	Cur	cin	oma	141	14 1	Brair	1	Onset and Death MouTUS
	/Medical		resulting in death)	Due to (or as a conseque	nce of):					W.	0 49	2191	\$
	Examiner		Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque									
	ed sit	liner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	irice or <sub>j</sub> .								
	xecut end al-trar	Examin	that initiated events c resulting in death) Last	Due to (or as a conseque	ince of):								
760,	te be executed ysicien end ne burial-transit	calE	d										
89	death certificate I attending physi d for use as the b												,
Вох	h cert endin	M/ug	23b. Was decedent pregnant	yes, outcome of pregnand		Ectopic pr	regnancy				23d.	Date of de Month	livery Day Year
). B	Physician: The law requires that the death certifical tris certificate hes been signed by the attending phyral director, page 2 should be detached for use as th	Physician/Medi	in the past 12 months?	☐Pregnant at time of dea ☐ Unknown		Other (sp	ecify)					WOTE	Duy Four
P.O.	that the de ed by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions contribut	iting to death but not result	ting in the u	nderlying c	ause div	en in Part	I.	23e. Did	obacco use	contribute to	o the cause of death?
	ires tha signed d be del	Completed by	5 nd Stace	COPD		g	3.V				Yes 2□N		robably 424Unknown
of Vital Records,	w require been si should t	etec								24a. Was	an 2	4b. Were a	utopsy findings available
Rec	The lav	E G								auto perfe	psy ormed?	prior to death?	completion of cause of
ta	ician: Th certificate rector, pag		25. Was case referred to medical					26. Plac	e of Death	1 ☐ Yes		1 🗆 10:	2 2 140
Ž	ysician: ils certific director,	To Be	examiner? 1 ☐ Yes 2 € No. Hospi	tal: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	nt 3 🗆 D0	Oth Oth			me 5□Res		Other (Spe	acify)
	og Ph ter th		27. Manner of Death Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time o Injury	of 2	28c. Injur Wor	y at k?		28d. Describe	how injury or	ccurred	
Sio	endir eath. or: Al	catic	2 Accident investigation			М		Yes 2		201 1	(0)		
Division	or Att fter d Sirect in by 1	Certification;	3 Suicide 6 Could not be determined 2	<ol> <li>Place of Injury - At hon building, etc. (Specify)</li> </ol>	ne, farm, st	reet, factor	y, office			City or To	wn, State)	umber or H	ural Route Number,
	pital		29a. Certifier Sertifying Physicia	n: To the best of my know	rledge, deat	th occurred	at the tir	me, date a	ind place, a	and due to the	cause(s) an	d manner a	s stated.
	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check only 2 Medical Examiner:	On the basis of examination and manner stated.	on and/or in	rvestigation	i, in my o	pinion, de	ath occurr	ed at the time	date and pla	ce, and du	e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	<i>(</i> 1 -		29	c. Licens	e number			29d. Dateys	igned (Mon	th, Day, Year)
			1 Artuno	nella	_		H26	5154			11	11	107
		1	30. Name and address of person who comple								- 1		
100		11	Dr. Daniel Miller,	69 Wolf Ac		rive,	0ał	cland	, MD	21550			
	St Regist	ate	31. Date filed (Month, Day, Year)		8	barret	0						
	1.09.0		4 4	A second	-	A STATE OF THE PARTY OF THE PAR	Jan. 17						

1. Decedent's Name (First, Middle, Last)  Physician  Bertha Tower	2. Date of Death Month January 8	. No. 3. Time of Death
/Medical Del Cha Towel		3, 2007 2:30 A <sup>M</sup>
Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location  Goodwill Mennonite Home  Grantsville	on of Death	4c. County of Death  Garrett
Director 219–56–9455 1 M 2DXF 98 Yrs. Months Days Hour	der 24 Hrs. 8. Date of Birth (Month, Day, Y Aug. 2, 1	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Grantsville		10d. Inside City ⊔mits 1 ☐ Yes 2 <b>X</b> No
MD Garrett Grantsville    MD Garrett Grantsville   106. Street and Number   107. Zip Code   108. Street and Number   7211 New Germany Rd.   21536   11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   13. Was Decedent of Hispanic If Yes, specify Cuban, Mexital Status   1. Never Married   2. Married   1. Yes   220 No		i. Citizen of What Country?
The state of the	Origin? (Specify Yes or No- ican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Secondary (0-12)   Secondary (	nost of working	b. Kind of Business/Industry
TO E TO DO NOT STATE OF THE PROPERTY OF THE PR	other's Name (First, Middle, Ma	·
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num		City or Town, State, Zip Code)
Communication (Margarities)	Date 20	c. Location - City or Town, State
20a. Method of Disposition  1 Separate 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery, crematory or other place)  Compared to the place of Disposition (Name of cemetery)  Compared to the place of Disposition (Name of cemetery)  Compared to the place of Disposition (Name of cemetery)  Compared to the place of Disposition (Na		eral Homes, P.A.
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a insequence of):  Due to (or as a insequence of):	isease_	years
d.    State   Composition   Co		23d. Date of delivery Month Day Year
÷ ā o I. Pan II. Other significant contituons contributing to death but not resulting in the underlying callse given in Pa	art I. 23e. Did tobac	2  co use contribute to the cause of death?
The law red page 2 should be complete	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
To the transport of the		injury occurred
determined 28e, Place of Injury - At home, farm, street, factory, office	City or Town, S	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  29b. Signal eand title of certifier  29c. License number  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29c. License number  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29c. License number  29c. License number	death occurred at the time, date	se(s) and manner as stated.  and place, and due to the cause(s)  Date signed (Month, Day, Year)
Markeyst a fram wo D766		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  4 May and address of person who completed cause of death (Item 23a) (Type, Print)  State  Registrar  31. Date flee (Month, Day, Year)  32. Registrar's Signature  AN 1 2007	hizeway c	1-8-2007 Pabland, ud 21550

			1 - For Stete Registrar	State o	f Marylan		artmen rtificat					iene	007	013	90
	Dhusisi		1. Decedent's Name (First, Midd	ile, Last)						2.	Date of Dea	th	Year Year	3. Time of	Death
	Physici /Medi		HARRY O. ULVILA				January 4,						Day Year 11:15 P M		
	Examir	ıer	4a. Facility Name (If not institution	mber)		4b. City, Town, or Location of Death					4c. County of Death				
			5079 Annemesse	+					risfi					erset	
	Funeral		5. Social Security Number	6. Sex 1XXM 2□ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	Date of Birth (Month, Day)	Year)	9. Birthr	olace (State ontry)	
	Director		032-26-0339 Usual Residence of Decedent	7171	71					Fe	enruary	8, IS	935 Mass	achuse	tts
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itama 23e or 28a-f show any injury or other traumatic evant. The M. dical Examinar must be invitified at once.		10a. State 10b. Count	у	10c. Cit	y, Town or Lo	ocation						1	IOd. Inside Ci	ity Limits
		ţ	Marer land Cor	margat			Crisfield							1 🗆 Yes	2 <b>X</b> No
		Director	Maryland Sor 10e. Street and Number	merset				10f. Zip Code				0g. Citiz	en of What Cour	ntry?	
		<u>a</u>	5079 Annemesse	x Road			21817							USA	
		Funeral	11. Marital Status		edent Ever in U.	J.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert					ecify Yes or No- Rican, etc.)  14. Race - American Indi Black, White, etc.				
98		교	1 ☐ Never Married 🎎 Ma	rried TXXYes	TXXYes 2□No 1961—			1 Yes 2 No Specify:				Specify: White			
5-0036		d by	3 Widowed 4 Divorce	d Year or D	ates: 19	75			ai						
5		Completed	(Specify only high	nt's Education est grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done di	uring mos	at of working		16b. Kin	nd of Business/In	dustry	
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9			17. Father's Name (First, Middle	, Last)			Co=	Owner		er's Name (F	First, Middle, I		t <u>Manufa</u> Sumame)	acture	C
Maryland		To Be							Seppa						
ary		-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address					; City or	Town, State, Zip	Code)	
		1 3	Loretta Ann Ulv	vila (Wife)	)	5079	Anner	nesse	x Ro	ad - (	Crisfie	eld,	Marylar	nd 218	17
Baltimore,		13	20a. Method of Disposition		20b. P	lace of Dispo emetery, crea				Date			cation - City or To		
Ĕ			1 ☑ Burial 2 □ Cremation 1 ☑ Donation 5 □ Other (		State					Ian 8	2007	ria.	field, N	//	- A
alti			21. Signature of Funeral Service	Licensee	123		2. Name an	d Address	of Facilit	ty				aryrai	IG
Ω	Dep Imp eny eny	6 8	Mary Beth	Bradshaw-F	ruitt	0					uneral		e <del>eld,</del> Mar	امحداديه	2101
	/Medical Examiner	dical resulting in death)  Due to (or as a contequence of):  Due to (or as a contequence of):  Due to (or as a contequence of):  Due to (or as a contequence of):								iŧ				Interval Bett Onset and D	
<ol> <li>Box 68760,</li> </ol>	The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d	come of pregna aint at time of de	ncy	]Ectopic pre					23	3d. Date of delive		/ear
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ords,		ted by	ATRIAL FIBRILLATION									bacco use contribute to the cause of death?  es 2 No 3 Probably 4 Unknown			
of Vital Record		Completed	HYPERTENSION					24a. Was an autopsy perform 1 □ Yes 2,					24b. Were autopsy findings available prior to completion of cause of death?  ↑No 1 □ Yes 2 □ No		
Vita	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?		26. Place of Death (Check only				one)						
of	Hospital or Attanding Phys 4 hours after death. Funaral Director: Atter this e ely filled in by the funeral dir	2	1 Yes 2 No	-	1 Inpatient 2 ENOutpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)										
		lon	27. Manner of Death  1 Natural 5 □ Pendi	119	, Day Year) Injury Work?								ury occurred		
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	To the Hos within 24 h To the Fur completely	Me	29b. Signature and tiple of certifier 29c. License					License	e number 29d. I				Date signed (Month, Day, Year)		
)			> XIDE		M.D. 461536						JANUARY 8, 2007				
			30. Name and address of person	who completed caus	e of death (Item							10011	1-1010		
_			VIRGILIO BAUTI	STA 10	1-BMA	KET	STREE	T, F	OCOL	MOKE	CITY	M	ARYLANI	218	57
	Sta		31. Date filed (Month, Day, Year	) 32. H	egistrar's Signat	ture		,				,			,
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ORIGINAL

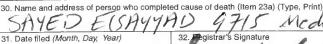
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2, 2007 January 11:10pm<sup>M</sup> Petrus J. van der Ham /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Potomac Valley Nursing Center Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F Yrs. Sept. 5, 1926 Netherlands Director 220-42-3703 80 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other than what is event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Maryland Montgomery Derwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15770 Buena Vista Drive 20855 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Automobile Mechanic Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Leonardus van der Ham Cornelia Diemel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15770 Buena Vista Drive, Derwood, MD 20855 Janske van der Ham (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/3/2007 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service License 23a Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Oneum onica **Physician** disease or condition resulting in death) /Medical **Examiner** an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) neral Director; After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. e Hospital or Attending Physician: The law 24 hours after death. Perneral Director: After this certificate has it

31. Date filed (Month, Day, Year) State **JAN 0 4** Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier



and manner stated.



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** JANUARY 1 2007 3:30 P<sup>M</sup> DONALD **EDWARD** WALLACE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12507 CYNTHIA COURT PRINCE GEORGE'S UPPER MARLBORO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 □ F 223-70-0779 JULY 28 1950 VIRGINIA Director 56 Usual Residence of Decedent the Maryland r 28a-f show notified at 10c, City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 No PRINCE GEORGE'S UPPER MARLBORO Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be n with U.S.A. 12507 CYNTHIA COURT 20774 death v Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 □ No If Yes, Give Year or Dates: , or 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 21 No Specify: Specify. BLACK δ 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AC MECHANIC PRIVATE 1 and 2 should be filed w Health and Mental Hygier em 27 is marked other th 12th17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VELEMA HARRTS FREDRICK WALLACE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any Injury or other trau 12507 CYNTHIA COURT UPPER MARLBORO, MARYLAND 20774 OPHELIA WALLACE/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State MD VETERAN'S CEME 1/8/2007 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MENINGIOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 24a. Was an page 2 autopsy performed? certificate 1∐ Yes 2√∑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ဂ္ 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.O. Records, Division or Vital Hospital or Attendi 24 hours after death. 9 Funeral Director; A completely filled in by thin 24 hours at

To the within 2

State Registrar

Medical

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

20422

29c. License number 29d. Date signed (Month, Day, Year) MD#33255 **JANUARY 4, 2007** 

RAREN ANN BLACKSTONE, MD vertex and address of person who considered cause of death (Item 23a) (Type, Print)

VETERANS AFFAIRS MEDICAL CENTER 50 IRVING STREET, NW WASHINGTON, DC

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2007 **JAN 05** 



and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** CLAUDE WALKER 1,2007 Jan. 5:34P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 1 XM 2 ☐ F 212-66-7939 50 May29,1956 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 XIYes 2 □ No Montgomery Silver Spring Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15711 Radwick Lane U.S.A. 20906 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23s any injury or other traumatic event, the Medical Examiner must once. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Private llth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret King Melvin Walker 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15711 Radwick Ln Silver Spring, MD 20906 Margaret S. Walker- Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/6/2007 4 ☐ Donation 5 ☐ Other (Specify) Ash Memorial Cem Sandy Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTROINTESTINAL BLEED **Physician** /Medical Due to (or as a consequence of): Examiner PANCREATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and DEHYDRATION Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alcohol Abuse 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsv performed? Yes 2 2 No **Ž**∏ No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 11 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the f 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jan. 2, 2007 D60826 hama hard

State Registrar 31. Date filed (Month, Day, Year) **JAN 0 4** 

Kshama Garg, MD 1500 Forest Glen Road Silver Spring, MD 20910 32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 1, 2007 Year **Physician** 9:00A. M William Winton Warren, Sr. /Medical <sup>4a. Facility Name (If not institution, give street and number)</sup> 3112 Gracefield Road, Parkview#617 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Examiner Montgomery 8. Date of Birth NoV • 13, 1914 9. Birthplace (State or Foreign Jakin, Georgia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Min. Hours 1 X M 2 □ F 92 260-22-4124 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. and the file R 27 is marked other than "natural", or items 23a or 28a-f show ant: if item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Silver Spring Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 United States 3112 Gracefield Road, Parkview#617 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FBI Agent U.S. Government 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Naomi Collins 17. Father's Name (First, Middle, Last) Be Ethel Naomi Manning Gilbert ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 20904 3112 Gracefield Road, Parkview#617 Silver Spring, Md. 19a. Informant's Name/Relationship (Type. Print) Ruth Ingle Warren -wife Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Important: if any injury or once. Lakemont Memorial Gardens 1/4/2007 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Concestive Heart Failure years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Aortic Stenosis years Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D34590 January 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JAN 03 2007

**ORIGINAL** 

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Day

200

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician Robert Clifford Wathen IANUARY 2007 12:04 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Leonardtown St. Mary's Hospital 9. Birthplace (State or Foreign 8. Date of Birth
(Month, Day, Year)
May 10, 1948 If Under 1 Year If Under 24 Hrs. 6. Sex 1XXM 2□ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Mary Land Yrs. 58 215-54-6963 Director Usual Residence of Deceden 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State in then "naturel", or freme 23a or 28a-f show the Medical Examinational be notified at 1 Yes ZXNo Completed by Funeral Director Mechanicsville St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20659 28586 Old Village Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 27 No filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter Pages 1 and 2 should be filed virunent of Health and Mental Hygie tant: If Item 27 is marked other taury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Addie Martha Lee Burch John Briscoe Wathen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 s
Department of Health ar
Important: if Item 27 ie
eny injury or other trau 24245 Maypole Road, Leonardtown, Maryland 20650 Joseph Edward Wathen / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition January 1 XBurial 2 Cremation 3 Removal from State Joseph's Cemetery 12. 2007 Morganza, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death? Se 10515 Physician /Medical Due to (or as a consequence of) Examiner lonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ivision of Vital Records, P.O. 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete hes irector, page 2 autopsy performs 1 ☐ Yes 2) No Attending Physician: 26. Place of Death | Check only one 25. Was case referred to medical Be Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ieral Director: At er this filled in y the funeral di 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 To the Hospital o within 24 hours of To the Funeral Di The Certifying Physician. Furthe best of my knowledge, death coourned at the time, date and class and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 25a. Confiler (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5236 9.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. MARYS HOSPITAL LEONARDTOWN MD 20650 DAVID ALLEN 31. Date filed (Month, Day, Year) JAN 10 32 Registrar's Signature State Registrar

FOBERT CLIFFORD WATHEN

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month 2007 12:42 pm **Physician** 0.1Jan Robert Edwin Warner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster 1418 Richardson Road Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) May 15 1 If Under 1 Year 7. Age (In yrs. lest birthday) 6. Sex 1 ☐ M 2 ☐ F 5. Social Security Number Funeral Days Months Yrs. 1940 May PΔ Director 220-46-0082 66 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10a. State 10b. County show rthan "natural", or items 23a or 28a-f shov the Madical Examiner must be notified at 1 ☐ Yes 2 DaNo **Funeral Director** Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21158 1418 Richardson Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify. Baltimore, Maryland 21215-0020 White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Farming Farmer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if item 27 is merked otheny Jujury or other traumatic event Be Ruth Hesson ၉ Russell Warner 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1418 Richardson Rd Westminster, MD 21158 Audrey Warner/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/06/07 Keymar, MD Keysville Union Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Pritts Funeral Home and Chapel, P.A. 21. Signature of Funera rvice 412 Washington Road Westminster, MD 21157 23a. Pedi. Inter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** ASCUN Immediate Ceuse (Final disease or condition resulting in death) Year 5 /Medical Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobecco use contribute to the ceuse of death? signed by the at id be deteched for Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ page 2 should be 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed peen After this certificete has 1 ☐ Yes 2 ☐ No 2 110 1 ☐ Yes Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Markesidence 6 □Other (Specify) ၉ 1 Ves 2 □ No To the Hospital or Attending Physi within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral dir 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier January 2, 2007 MIL 10051924 30. Name and eddress of person who complete cause of death (Item 23a) (Type, Print) MD 2973 Man chester Rd Manchester MD21102 12 P. Flenderson 5. Herbert 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State JAN 04 2007 Merca Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Duk 01 2001 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City

If Under 1 Year | If Under 24 Hrs. | 8. Date of Firth
(Month, Day, Year) Hopkins Hospital )ohns 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F 63 June 28, 1943 South Korea Director 530 87 5189 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Item 27 is marked other than "natural", or Items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21043 3210 Wheaton Way Apt.F Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Asian Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Asst. Pastor 4vrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Se Joong Yoon Won Ha Song 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important if flem 27 is
any injury or other traur 3210 Wheaton Way Apt.F Ellicott City, MD 21043 Ji In Yi/daughter Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gards 1/6/2007 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01442 4112 Old Columbia Pk. Ellicott City, MD 21043 Vernia 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 Loves **Physician** Subarachnoid Henorches /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-trar and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 ☐ Other (specify) signed by the a o م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA <u>S</u> After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier D0063682 MD SQ (2) 30. Name and address of person who complete use of death (Item 23a) (Type, Print) 600 N. Baltinore MID 21287 Street 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Angelo Stephen A		nson State of Maryland / Department of Health and Mental Hyg - For State Certificate of Death		200	7 01399
Physician		Registrar	2. Date of Death		3 Time of Death
Medical Examine		Angelo Stephen Atkinson 1	Month January 16	Day Year , 2007	1904 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital  Baltimore		4c. County of Death	
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth		nplace (State or
Director		$218-02-8101$ 1 M $_{2}$ F $45$ Yrs. Months Days Hours Min.	Jana	7, 1961 Foreign	intry) Md.
aus	-	Usual Residence of Decedent  10a State		1	10d. Inside City Limits
<u>*</u> .	_	Md N/A Baltimore			1 Yes 2 No
Maryla 28a-f s	Ulrector	10e. Street and Number 10f. Zip Code	10	g Citizen of What Coun	try?
death with the Maryland or items 23a or 28a-f show must be notified at once.		1625 N. Monroe St. 121217		USA	
ath wi	runerai	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No		14. Race - Americ White, etc.	an Indian, Black.
after de al". or ner m		3 Widowed 4 Divorced If yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify:		Specify: B	ack
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filed within 72 hours after death with the Maryland Hyggene do do then "natural", or items 23a or 28a-f she the Nedical Examiner must be notified at once		17. Father's Name (First, Middle, Last)	First, Middle, M		SIGNICATION
2121 uld be fi Mental marked	జ 일	19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Number or Ru	e Lural Route Numb	uller per City or Town State	Zin Code)
MD 212' d 2 should be Ith and Mental n 27 is marke umatic event	-	Mr. Larry Atkinson 1625 N. Monroe	St.	Balto. 1	11,21217
Head Head	Ī	1 Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit Pages I ar Department of Her Important: If lite mjury or other fr		4 Donation 5 Other Specify: Green Mount Cremetery (29	1/2007	Balto.	VIA.
Balti permit Departm Importa		22 Name and Address of Facility  10 Seph 1, Russ 1	uner	of Home,	2.A.
Physician	7	23a Part I. Enter tije disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List offly one cause on each line.	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Multiple Injuries			Death
James of the same		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	iner	f any, leading to immediate cause. Enter Underlying Cause			
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Box e death the atte	Physic	1 Yes 2 No 9 Unknown 9 Unknown		1	
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Vita	To Be	TV Tes 2 No	Home 5 F	Residence 6 Other	
Division of Vital Records, lat or Attending Physician: The law require is after death al Director. After this certificate has been si bed in by the funeral director, page 2 should be in the funeral director.				ow injury occurred truck by auto	
ivisior  I or Attend after death Director:	licat	2 V Accident Investigation 28e Place of Injury - At home farm street factory office building etc. 2	28f. Location (S	treet and Number or Rui	al Route Number City
Divis Hospital or 24 hours after Funeral Dire	Certification:	4 Homicide determined (Specify) Local Street	or Town, St Russell St & B	ate) ush St, Baltimore, MI	)
0		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done) Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at			
To the within 2 To the complet	Medical	and manner stated.  29b Signature and title of certifier  29c. License number		29d Date signed (Mor	- 13
		Quel		January 17, 2007	
4	}	30. Name and address of person who completed cause of death (Item 23a)  And Public MD Assistant Medical Examinar 111 Penn Street Baltimore MD 21201			
Sta	te.	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32. Reg. (rar's Signature)			
Registr		31. Date filed (Month, Day, Year) JAN 2 3 2007 32. Regulari's Signature			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 05:03a January 19 2007 CARROLL W. AUSTIN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death GRETAER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 **X**M 2 □ F 01-23-1915 91 VA 213-07-6781 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ¹₩Yes 2□No BALTIMORE MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 5315 KENILWORTH AVENUE 21212 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 BETHLEHEM STEEL BOTTOM MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES AUSTIN MARTHA STOKES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5315 KENILWORTH AVE. BALTIMORE, MARYLAND 21212 HESTER AUSTIN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1-24-2007 TIMONIUM, MARYLAND DULANEY VALLEY MEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 23a. Part1. Sheer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTIMORE, MD Approximate Interval Between Onset and Death Immediate Cause (Final 1 year Atrial tibrillation disease or condition resulting in death) Due to (or as a consequence of): Heart failure YROUS Sequentially list conditions Due to (or as a conse juence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hupertension Due to (or as a consequence of) oronary 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available

**Physician** /Medical Examiner

Examiner Division or Vital Records, P.O. Box 68760, 400 or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

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Director

Funeral

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Completed

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Ifem 27 Is marked other than any injury or other trainment.

attending physician and for use as the burial-trar signed by the

Physician/Medical

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Certification:

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			performed?  1 Yes 2 No 1 Yes 2 No								
25. Was case referred to medical		26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1     Hospital   1    Hospital   2   ER/Outpatient   2   ER/Outpatient   1	ome 5 Residence 6 Other (Specify)									
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		, factory, office	<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>								
29a Certifier 1 Certifying Ph	hysician: To the best of my knowledge, death of	ccurred at the time, date and place.	and due to the cause(s) and manner as stated								

29a.	Certifier
	(Check only
	one)

Kenu

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Thomas MD 29c. License number D 60630

Charles St

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21204

State Registrar

O

6701 Thomas 3. Registrar's Signature 31. Date filed (Mo.



within 24 hours a

			1 - State of M	-	artment of Health and Nartificate of Death		ene2007	01401
			Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Time of Death
	Physici /Medio	_	Clyde Ayers			Jan	Day Year 17 2007	1:30 A M
	Examir		4a. Facility Name (If not institution, give street and number,		4b. City, Town, or Location of Death		4c. County of Death	12.30
			Harford Memorial Hospital		Havre de Grace		Harford	
	Funeral			je (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Aug 8, 1	9. Birth	place (State or Foreign
	Director		232-56-8816	9 Yrs.		Aug 8, 1	937 WV	
	and w	}	Usual Residence of Decedent           10a. State         10b. County	10c. City, Town or Lo	ocation			Od, Inside City Limits
	dary!	៰	MD Harford	Edgewood				1 ☐ Yes 2X No
	death with the Maryland rms 23a or 28a-f show r.must be notified at	Director	10e. Street and Number	Lugewood	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	fler death with r items 23a or		1002 Magnolia Wood Lane		21040		USA	,.
	ms 2:	Funeral	11. Marital Status 12. Was Decedent		Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	can Indian,
ယ	or ite		Armed Forces' 1 ☐ Never Married 2 【※ Married 1 【※ Yes 2 ☐	No	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
93	hours a tural', c	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	55-64	1 ☐ Yes 2⊠ No Specify:		Specify: whi:	te
5-0	within 72 hours after ane. than "natural", or ite	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work	sing 1	6b. Kind of Business/In	dustry unk
2	ithin	jd L	Elementary/Secondary (0-12) College (1-4or	5+) life.	DO NOT use retired)			unk
2	be filed withing the Hygiene. Id other than event, the M	S	12 none  17. Father's Name (First, Middle, Last)	Train	ing Specialist	e (First, Middle, M.	laidan Comana)	
Maryland 21215-0036	otal h	Be						
Ž	should be fand Mental be marked of	2	Kenneth Bernard Ayers  19a. Informant's Name/Relationship (Type, Print)	10h Mailir	Alice Ja ng Address (Street and Number or Rur	ne Robert		Cadal
Ma	es 1 and 2 should to the alth and Ment litem 27 is marked rother traumatic e				Marnolia Wood Lan			
	Heal Heal tem 2	1	Ruth Ayers/spouse  20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Oc. Location - City or To	
Baltimore,	ages ant of at: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	cemetery, crei	natory or other place)			
Ħ	permit. Pages 1 Depertment of He important: if iter any injury or oth		21. Signature of Funeral Service Licensee		. Name and Address of Facility			
ä	Den im g		Anthony D. Pleasant	∦ St	ate Anatomy Board Altimore, MD 21201		Baltimore S	treet
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d e death. Do not ent	er the mode of dying, such as corriac	or respiratory arres	st,	Approximate Interval Between
	Pnysician	is i	Immediate Cause (Final disease or condition	Nyocaro	1:1 + 1	- 4m		Onset and Death
	/Medical		resulting in death)	consequence of):	cal infra	China		e 1 Mount
1	Examiner		Sequentially list conditions. b.	+Therose	levotic Can	hovascu	ela Pisser	10 years
	D #	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of).	11 11			
	ecute and I-trans	Examin	that initiated events c.	west	Melo			10 years
8760,	requires that the death certificate be executed been signed by the attending physicien and hould be detached for use as the burial-transit		Due to (of as	a consequence of);				
687	physicate sthe	dical	d.					
×	eath certific attending p I for use as	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy			23d. Date of delive	200
Вох	atter atter I for u	clar	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)		Month	Day Year
O.	t the de by the tached	lys	1 Yes 2 No 9 Unknown		(			
Р.	res that igned b	by Physician/Me	Part II. Other significant conditions contributing to death I	out not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
Records,	w require been sig should b	be b				1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Minknown
ပ္ထ		plet				24a. Was an	24b. Were auto	psy findings available
	0 - 0	Completed				autopsy performs	ed? death?	mpletion of cause of 2□ No
of Vital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical		26. Place of Deat	h Check only one		20110
<b>2</b>	S 20	10	examiner? 11 Yes 2 No Hospital: 1 Inpati	ent 2 ER/Outpatier	t 3 DOA Other: 4 Nursing Ho	ome 5 Residen	ice 6 Other (Specif	y)
- =	<b>a</b> <u>a</u> <u>a</u> a		27. Manner of Death 28a. Date of Inj 1 ★ Natural 5 □ Pending (Month, Da	ary 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
Sio	Attending r death. sctor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
Division	or Ati	Certification:	determined 286. Place of In	ury - At home, farm, str c. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	pitel	ဒီ	29a. Certifier 1 Certifying Physician: To the best					
	Hos 24 hc Fun etely	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	if examination and/or in	vestigation, in my opinion, death occur	red at the time, dat	e and place, and due to	tated. the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funers! Director: A completely filled in by the fu	Me	29b. Signature and little of certifier		29c. License number	290	d. Date signed (Month,	Day, Year)
			25/200	D. An O	H7907-	2 1	11111011 17	7 2007
-			30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	7	in many.	
			VEDER CHARSTE 13	3081868	Es Orke lle	y the	cound M	£ 21040.
	Sta		31. Date filed (Month, Day, Year) 32. Regist	ar's Signature	-			
ß,	Registr	ar	JAN 2 3 2007	is for	W			

State of Maryland / Department of Health and Mental Hygiene. UU / 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Josephine 18, 2007 9:30 A Barbara Ammon January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlestown Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🂢 F Yrs. Director March 19, 324-05-3113 89 Illinois 1917 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla nent of Heeth and Mantal Hygiene.
sair; if team 27 is marked other than "natural; or items 23a or 28e-f show ury or other treumatic event, is a Madical Exams as must be notified at ury or other treumatic event. 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 719 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify. 3 ₩idowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Veterinary Supplies Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Charles Josephine Heinz Cremer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 Log Trail Way, Reisterstown, MD John A. Ammon/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: if the
ony injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/20/07 Metro Crematory Catonsville, Maryland 21. Single of Funeral Service Licent Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Fi ter the disease, or complications that shock or he it failure. List only one cause on Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Immediat ( Cause (Final disease of condition resulting in leath) jears **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, ettending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ icete hes been significate page 2 should b 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No certificate 1 Yes 2 No 1 Yes or Attending Physician: Be ( funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: Certification: To 2 ER/Outpatient 3 DOA Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Pis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☑Natural 2 ☐ Accident To the Funeral Director: Al To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 3098 ddress of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Ln Codonsville MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per inf 8863 1-30-07 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Πav **Physician** 200 UAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ROCKVILLE MONTGOMER S HADY GROVE 8. Date of Birth (Month, Day, Year) Dec. 24, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5 Social Security Number 6. Sex **Funeral** Min. Days Hours 1₩ M 2□ F India 225-71-4001 63 Dec. 1943 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 TYes 2X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified a once. Germantown Director Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20876 11109 Little Fox Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 21 No Specify. Saltimore, Maryland 21215-0036 Specify: Asian Indian ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Banking Bank Teller 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karthyani Raman Narayanan Aratt 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11109 Little Fox Ln., Germantown, MD 20876 .R. Aratt / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 22. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Montgomery Crematorium, Ind. 2007 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland Berra A. Tumphirey Tuneral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licersee M00896 7557 Wisconsin Ave., Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart editire. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Zelays **Physician** ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner HIPETENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed DISPHAGIA the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician DISTASE. ALZITEIMERS IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed ector, page 2 should be def Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) 1 Matural 5 Pending investigation in 24 hours after when the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and add so of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr., Rockville, MD

DHMH 17 Rev 1/2001

State

Registrar

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32. Registrar's Signature

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2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2 0 **Physician** Anatoli Arikos 12:30 AM 01 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Care Center Johns Hopkins Buy View Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 2 4 4 Year 1 8 Months Days Hours Min. Pontas 1 M 2 S F 88 218-42-4248 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1√2 Yes 2 □ No Director Baltimore City MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21224 505 A Fairview Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after of teath and Mental Hygiene. m 27 is marked other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Tratsides Darthena Anathnacedes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Doxia Loizou - Granddaughter 505 A Fairview Ave., Baltimore, MD 21224 item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 1-23-2007 Baltimore , MD Date 20c. Location - City or Town, State permit. Pages 1 a
Department of HeImportant: If item
any injury or othe 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestill heart years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** diletes nears Sequentially list conditions, if any, leading to influedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine aftending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4□Pregnant at time of death signed by the at d be detached for 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has l autopsy performed? 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director. Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01/21/2007 P0060052 MA

Registrar
DHMH 17 Rev 1/2001

State

lo

Baltimore / Mp 21224-2734

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Weiss

Carlos

31. Date filed (Month

5200 Eastern AVE.

32. egistrar's Signature

					delible ink. Ensure Al	-	_	
			_ State		artment of Health and M rtificate of Death		2001	0   4 0 5
		Ĩ	Registrar  1. Decedent's Name (First, Middle, Last)	Cer	uncate of Death	2. Date of Death	. No.	3. Time of Death
	Physici	an	CHARLOTTE LOUISE BR	VCONT ADMOLD	,		19, 2007	
5	/Medic		4a. Facility Name (If not institution, give street and number)	ISON ANNOLD	4b. City, Town, or Location of Death	January	4c. County of Death	8:31P M
	Examin	er	ATLANTIC GENERAL HOSPITA	F	Berlin		Worcester	County
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign ntry)
	Director		215-05-5045 1□M 2XF	88 Yrs.	Months Days Hours Min.		8 Mary	land
	p .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	aryla •hov	_	Maryland N/A		City, Maryland			1 X Yes 2 □ No
	he M	ecto				100	. Citizen of What Cou	
	atter death with the Marylan or Items 23e or 28e-1 show reliner mark by richthed at	by Funeral Director	105.2 Co. 1		10f. Zip Code 21212	109	USA	intry s
_	eath	era	1253 Cedarcroft Road  11. Marital Status 12. Was Decedent	Ever in U.S. 13 \		ecify Yes or No-	14. Race - Ameri	can Indian.
W	iter d	E	Armed Forces	No	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
203	urs a		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: W	nite
C 20 5-0036	72 hours naturel',	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation	na 16	b. Kind of Business/Ir	dustry
272	within 72 hours after death with the Maryland ane then "naturel", or items 23s or 28s-1 show the Madical Examinar nast by notified at	Completed	Elementary/Secondary (0-12) College (1-4or	5+)	kind of work done during most of work DO NOT use retired)			
₹ 8 <u>2</u>	TI DE L	ပိ	12th	HO	memaker	(First, Middle, Ma	Own Resid	lence
	e da iai b	To Be	17. Father's Name (First, Middle, Last)  Harry Grant Bryson			Edmonia		
2 7 2	d Me mark mark	۴	19a. Informant's Name/Relationship (Type, Print)	19h Mailír	ng Address (Street and Number or Rura			2 Code)
N = B	ges 1 and 2 should t of Health and Mer if Item 27 is marks or other traumatic		Eleanor Barrett (Daughter)		Gulf Stream Drive,			
000	Hea Hea Hem		20a. Method of Disposition	20b. Place of Dispo			c. Location - City or T	
	Pages ent of nt: If i		1 Strial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	ark Cemetery 1/25	/2007	altimore.	Maryland
炎 드	permit. Pag Department Important: I any Injury o		21. Signatule of Eugeral Service Licensee	22	2. Name and Address of Facility			
山口音	9 9 5 9		Martin D. Lawson	6	MITCHELL-WIEDEFELD 500 York Road, Ba	1+imara	Maryland '	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Clostnd		le colitis			Onset and Death
	/Medical		resulting in death)	a consequence of):				
	Examiner	L	Sequentially list conditions, b.					
J	ed sit	Examiner	riany, leading to immediate cause. Enter Underlying Cause (Disease or injury	à consequence of):				
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687	certificate nding phys use as the	ed	u					
Вох	n cert anding use a	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		Ectopic pregnancy		23d. Date of deliv	
	death of etten	Physician/Medi	in the past 12 months?  1 ☐ Yes 2 ☐ No		Other (specify)		Month	Day Year
7 o.9	at the de by the	Ę.	9 Unknown			an Didust		
100	The law requires that the death certificate te hes been signed by the ettending physinge 2 should be detached for use as the	Ď	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	239. Did 100ai	cco use contribute to t	bably 4 Unknown
主るは	w requir been si should	Completed		· · · · · · · · · · · · · · · · · · ·				
ನ್ಯಾಹಿ	The law te hes t age 2 s	훁				24a. Was an autopsy performe	prior to co	oppsy findings available ompletion of cause of
27.00	. 10 ct					1 ☐ Yes 2 ☐		2 1 No
502		o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpati	ent 2 ER/Outpatier	Other	n (Check only one)	ce 6 ☐Other (Speci	6.1
0 7		<b>-</b>	27. Manner of Death 28a. Date of Inj			28d. Describe how		197
D 200	Attending or death.	ig ig	1 ☑Natural 5 ☐ Pending (Month, Di 2 ☐ Accident investigation	ay Year) Injury	M 1 Yes 2 No			
S. S. S.	i or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not be determined 28e. Place of Ir building, e	jury - At home, farm, str tc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Aur State)	al Route Number,
に供	rs after ral Direct	Cert						
Q V	To the Hospital or A within 24 hours after to the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the bess 2 Medical Examiner: On the basis and manner s	of examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and fille of certifier		29c. License number	290	I. Date signed (Month,	Day, Year)
-			1 Class		D5361Z		1/20/07	
			30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	0 2181	1	
_	l		Andrea - Jailer 9733	rar's Signature	y Hr. Berling M	1) 211		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  1AN 2 3 2007	Signature				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7<sup>Day</sup> 19,2<sup>Y</sup>6a07 January Anna Marie Busick 7:30AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Gilchrist Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | 7, 1931 Birthplace (State or Foreign \_ Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1 □ M 2 1 F 213-28-8647 75 Baltimore, MD Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2810 Kings Ridge Rd. Apt. F 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Stationary Elementary/Secondary (0-12) College (1-4or 5+) Company Clerk N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ambrose Camponeschi Margaret Lombardo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Busick, Sr.- Spouse 2810 Kings Ridge Rd. Apt. F Baltimore, MD21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 1/23/2007 Parkville, MD 4 Donation 5 DOther (Specify) 21. Sign Lure of Furnital Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) least (Lover Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Year Month Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown

Physician /Medical Examiner

attending physician and for use as the burial-trar

that the death certificate be executed

The law Jas

or Attending

death.

Box 68760.

P.O.

Division or Vital Records,

**Physician** 

/Medical

Examiner

10a. State

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Director

Funeral

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Physician/Medical

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Medical Certification: To

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Director:

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**Funeral** 

Director

show r 28a-f show notified at

r than "natural", or Items 23a or 7 the Medical Examiner must be n

other!

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Teath 1 Natural 2 Accident 3☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AND J. Walks W 6701 N Convey St / Browne M9

		•	1- State of Maryland / Dep	artment of Health and Nertificate of Death		ene 007 01407
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Catherine B. Barnes		Jan.	Day Year 21 2007 9:10A.M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
1			Broadmead	Cockeysville		Baltimore County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, ) May 28,	
	Director		220-12-5864 <sup>1</sup> □M 2 <b>∑</b> F 82 Yrs.	Months Days Hours Min.	May 28,	1924 Maryland
	р <b>,</b>		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	tion		10d. Inside City Limits
	shov	_	Maryland Baltimore County Cockeys			1 ☐ Yes 2 🖄 No
	88-f	octo				
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Exactions must require the incilities at	Funeral Director	10e. Street and Number 13801 York Road	10f. Zip Code 21030	109	g. Citizen of What Country? United States
	dea arms	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
98	or its	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: White
21215-0036	hours urai'	d by	3 Widowed 4 Divorced Year or Dates:	de de deservo		
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12	within ene.	mc	Elementary/Secondary (0-12) College (1-4or 5+)	ne Maker		Own Home
	fited Hygin ther ant, t		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "traumatic event, the Me.	o Be	Charles H. Benson	Marie Me		
7	mark mati	Jo		ing Address (Street and Number or Rur		City or Town, State, Zip Code)
Ma	id 2 s lith ar 27 is trau		1.1.1	1 York Road Cocke		
စ်	1 an Hea tem 2	1	20a. Method of Disposition 20b. Place of Disp	osition (Name of		Oc. Location - City or Town, State
õ	ages int of t: If it			matory or other place)	33 3007 E	orest Hill, Maryland
3altimore,	permit. Pa Departmen Important: any Injury	}		22. Name and Address of Facility	1	orest mili, maryland
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		I Scar of Telow	caceful Alternativ 2325 York Road Time		raliCrematica Ctr. P.A cryland 21093
			23a. Part1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	Interval Between
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	/Medical		resulting in death)  Due to (or as a consequence of):	0		
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8760,	death certificate be execul e attending physiclan and nd for use as the burial-trar	dical	d.			
9 ×	leath certific attending p I for use as	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			and David delicate
Вох	attend attend for us	lan	in the past 12 months? 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
o.	B € €	yslc	1 Yes 2 No 9 Unknown	Cities (specify)		
٥.	that the ed by	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use combute to the cause of death?
ds,	Se Ded	d b	T.HD		1 🗌 Yes	2 12 No 3 Probably 4 Unknown
Ö	w requir been si should	Completed	DM turnett		24a. Was an	24b. Were autopsy findings available
360	e la has	ld m			autopsy perform	prior to completion of cause of
al F	The age		0540000515			No 1 ☐ Yes 2 ☐ No
Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othon	h (Check only one	
of	this al di	5	T Tes 22 No T Inpatient 2 ENOutpatie	ant 3L DOA 4 Phiursing Ho	ome 5 Residen 28d. Describe how	ce 6 Other (Specify)
ű	ding In. After funer	lon	1 ■ atural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe non	injury occurred
Si	Attending in death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f Location (Stre	eet and Number or Rural Route Number,
Division	or A after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	treet, raciory, office	City or Town,	
	Hospital 4 hours E Funeral lely filled	Ö	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, data and place	and due to the car	uen(e) and manner as stated
		edical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	Mithin 2	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	F 3 F 8		12 C11111 200	DZTZ	92	1/22/200
	9		1) Martin // ht	Driet)	10	11001,001
	10	1 "	30. Name and address of person who completed cause of death (Item 23a) (Type	10001 1/m	K. RN	Cockersville
	1		31. Date filed (Month, Day, Year) 22. Registrar's Signature	113001 YOF	114	y wright 11 leg 11
	St Regist	ate rar	31. Date filed (Month, Day, Year)  AN 2.3 2007	ules.		U
	9.00		JAN 7, 1 LUUI ASSA			

CATHERINE & BARNES

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		•	For State Registrar	ricas			nd / Dep	artme	nt of H	lealth and l Death			2007		08
	- 10		1. Decedent's Name	(First, Middle, I	Last)						2. Date of D Month	eath Day	y Year	3. Time o	Death
	hysicia Medic/		Gloria	A. Be	ecker						1	18	2007	7:30	ΑM
	Examin		4a. Facility Name (If Upper C	not institution, g	give street and n	umber)		4b. City	, Town, or	r Location of Deat	h	4c.	County of Deat	n	
	3.		Med	lical (	Center					Air	10.0		Harfo		-
	uneral		5. Social Security No. 213-30-1		. Sex 1 ☐ M <b>X</b> (X)F		. <i>last birthday,</i> <b>74</b> Yrs.	Months	Days	II Under 24 Hrs. Hours Min.	(Month, D	ay, Year)		nplace (State untry)	
	rector	}	Usual Residence of								10/14	/19:	32 Ma	rylan	<u>d</u>
yland	Mou		10a. State	10b. County		10c. C	ity, Town or L							10d. Inside C	
e Mar	a-f sl	ctor	MD	Cec	cil		Nort	h Ea	st					1 🗌 Yes	2 <b>№</b> No
th th	or 28	Director	10e. Street and Num	nber				10f. Z	ip Code			10g. Cit	izen ol What Co	untry?	
) deeth with the Maryland	238 1451	ral	188 Brid	lgewood						1901			USA		
5 5	Item Der II	Funeral	11. Marital Status	ad 20 Margar	12. Was De	cedent Ever in Forces?	J.S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	lispanic Origin? (S an, Mexican, Puer	specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White		
36 P	l', or	by F	1 Never Marrie 3 Widowed		If Yes, C	avić		1 🗆 Yes	XXNo	Specify:			Specify: W	hite	
2 Pour	atura cal E	ted		15. Decedent's	Education		16a. Dece	dent's Us	ual Occup	pation	4	16b. K	ind of Business/	ndustry	
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Roce Pages	Important: If item 27 is marke any injury or other treumatic once.			☐Cremation 3 5 ☐Other (Spe	□Removal from	n State M	iorela	natary of	iemoj	rialJan	uary 2007	Pa	rkvill	e. MD	)
	ortar Injur	ì	21. Signature of Fuj			,	2	2 Name	and Addre	ss of Facility			800 Har rkvill		
Balt Permit Depart	any le		1 /at	to 6	Mh		Ā	vans nd (	rema	neral C ation S	hapel ervice	s S	arkvill	e <sub>2123</sub>	4
	A		23a. Part1. Enter the	e disease, or co	nly one cause on	each line.				_	c or respiratory	arrest,		Approxima Interval Be	tween
Phy	sician		Immediate Cause (	Final	· F	nd Sta	age L	ive	r D	)isease			46.44	Mont	
	edical miner		resulting in death)	4	Due to	o (or as a conse	equence of):	1	1	. /					
LA			Sequentially list cor	nditions,	b. He	patic or as a conse	Ence	phal	ope	athy				Month	15
pe	ısit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events	mediate rlying injury						curren	+			Mont	he
KER '60, be execute	al-tra	xar	that initiated events resulting in death) L	ast	Due to	o (or as a conse	iduence of):	•						1.0111	
CK6 760,	signed by the attending physicien and defeached for use as the burial-transit	cal			Ma	ssive	Right	- Si	ded	Hydr	othor	XS		Mont	hs
E (68)	as the						J								
4 8£.  . Box 68	endir r use	an/N	IF FEMALE: 23b. Was decedent			outcome of preg		Ectopic	pregnancy	v			23d. Date of del	,	V
A Geat	he att	Physician/Medi	in the past 12	months? No		gnant at time of		Other (					Month	Day	Year
LORIA ords, P.O. I	d by t	Phy	9 Unknown Part II. Other signifi	innet condition	• contributing to	do ath hut not re	aulting in the	un doch in o		ean in Bort I	23a Did	tobacco	use contribute to	the cause of	death?
S GLC Vital Records,	engis d be d	by	rait ii. Other signii	out condition	s contributing to	doain but not re	soung in the	underlying	Cause giv	on an Carci,			V	obably 4	
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Rec he law	has ge 2 s	d m									auto	psv	prior to (	completion of	cause of
<u>'a</u>	ficate or, pa		25. Was case refer	and to madical						00 Di -4 D-		ormed? 2 No	1 ☐ Yes	2 No	
M = =	s certi	o Be	examiner?		Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 🗆 🖸	Oth	ner .	ath <i>(Check only</i> Home 5 ☐ Res		6 Cother (Sne	rifu)	
20 p #	After this funeral di	-	27. Manner of Death	1		e ol Injury onth, Day Year)	28b. Time		28c. Injur Wor	ry at	28d. Describe			~'',	
165723 Vision of Vita Attending Physicien:	r: Aft	atio	1 Natural 2 Accident	5 Pending investiga		Jilli, Day 19ai)	Injury	М		Yes 2 □No					
	recto by th	Certification:	3 Suicide 4 Homicide	6 Could no determin	200, Fld	ce of Injury - At Iding, etc. (Spec	home, larm, s	treet, facto	ory, office		281. Location City or To	(Street ar	nd Number or Ru	ral Route Nur	nber,
Div Div	ied Del														
M800446572 Division of To the Hospital or Attending P Within 24 hours after death.	To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only	1X Certifying 2 Medicel Ex	ceminer: On the	basis of examin	nowledge, dea nation and/or i	th occurre	d at the tir	me, date and place opinion, death occi	e, and due to the urred at the time	cause(s , date and	) and manner as d place, and due	stated. to the cause(	s)
Tithe 1	mplei	Med	one) 29b. Signature and	title of certifier		anner stated.		2	9c. Licens	se number		29. Da	te signed (Monti	n. Day, Year)	
F 3	<b>¥</b> 8		▶ (200	· E (	1 0		0		7)	10/97	79	1	10	2 20	07
	<		30. Name and addre	ess ol person w	ho completed ca	use of death (Its	大)。 em 23a) (Tvne	, Print)	PC	10101	1.1	jan	wary IC	1, 20	J
2	1		29b. Signature and GU 30. Name and addr. ALBERT 31. Date filed (Mon.	S. Su	N, M.D.	, 171	6 Har	ford	Ros	d, Suite	105	FAL	LSTON.	MD S	1047
4	Sta	te	31. Date filed (Mon	th, Day, Year)	32.	Registrar's Sign	natur	0							
	Registr	ar	1811	0 0 2007	1 879 AA	STORY OF	127 5 1000	-							

			For	State of	Marylan					and M	ental Hy	giene	2007	01100
			State Registrar			Cei	tificate	of L	Death			Reg. No.	2001	01409
	Physici	an	1. Decedent's Name (First, Middle	,							2. Date of De Month	Day 21	Year	3. Time of Death  1:35 AM
	/Medic		John E. I		her)		4h. City. 1	Fown, or	Location o	f Death	<u> </u>	_	21 2007 1:3	
di	Examin	er	Gilchrist		501)		_	vsor.		, Douti			Balti	
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. I	last birthday)	If Under	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th V Yearl	9. Birth	nplace (State or Foreign Intry)
	Director		214-26-1268	<b>X</b>		77 Yrs.	IVIOITUIS	Days	Hours	IVIII I.	4/26	/192		ryland
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c, City	y, Town or Lo	cation							10d. Inside City Limits
	//aryis	ō		altimore			rkvil	lle						1 □Yes 2x No
	the N 28a-	Director	10e. Street and Number				10f. Zip	Code			T	10g. Citiz	zen of What Cou	untry?
	3a or	Ö	8313 Avono	dale Rd.					212	234			USA	
	death ms 2 r mus	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.	S. 13.1	Was Deced	ent of Hi			cify Yes or No Rican, etc.)	- 1	14. Race - Amer Black, White	
9	after or ite mine		1 ☐ Never Married 2 X Mar	ried 1X Yes 2			1 ☐ Yes 2		Specify:	i, i deito i	ilcan, elc.)			hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dat	tes:	46- P	dent's Usua	10				401-141-		
15	n 72 "nat ledica	Completed	(Specify only highe	nt's Education est grade completed)		(Give	kind of wor DO NOT us	k done d e retired	luring mosi )	of workin	ng	TOD. KII	nd of Business/I	ndustry
112	withi jene. r thar the N	E	Elementary/Secondary (0-12)	College (1-4	4or 5+)		sista						Tele	phone
	al Hygi other vent, tl	Be C	17. Father's Name (First, Middle,	, Last)							(First, Middle,		,	
/lar	ould be f Mental H narked of	To E	Lloyd	Burgesse	r				E	ran	ces 0	'Too	le	
Maryland	ds E E		19a. Informant's Name/Relations	, , , ,			-						r Town, State, Z	,
	1 and tealth		Shirley Bur	rgesser/w	20h P	lace of Dieno	3 Avo	ne of	- :		Park		e, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tra		ty⊋yBunal 2 ☐ Cremation		tate Mo	orela.	natory or ot	her place	ial	Janu	ary 2007		rkvill	
쁲	artme ortani injury		4 □ Donation 5 □ Other (5									0		rford Rd.
Ba	permi Depar Impor any ir		West of B	11/		E	Name and Vans	Fur	neral ition	l Ch 1 Se	apel rvice:	<sub>s</sub> Pa	rkvill	e, MD
			23a. art1. Enter the disease, o shock, or heart failure. Lis	r complications that car	used the death					_		_		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ocp 5	65	54	no	dvo	me				Onset and Death
5	/Medical Examiner		resulting in death)	Due to (o	r as a consequ	uence of):		Fa			-			8
2	Examine:	J.	Sequentially list conditions,	b. Due to (c	r as a consequ	nence of).								
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>4</b>	i as a consequ	derice oi).								
Ć,	execunate nandial-tra	Exal	resulting in death) Last	CDue to (o	r as a consequ	uence of):					-			
8760,	cate be executed ohysician and the burial-transit			d										
9	ng ph	Physician/Medical	IF FEMALE:											
Вох	leath certific attending p I for use as I	jan/	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Feta	Idéath 3∐	Ectopic pre					2	23d. Date of deli	very Day Year
	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9⊡Unknov	int at time of down	eath 5L	Other (spe	ecify)						
P.0	w requires that the deben signed by the should be detached		Part II. Other significant condit	ions contributing to dea	ath but not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
rds	quires n sign ald be	d b	chronic k	cidney o	Sise A	se, A	Der:	ph	264		10	Yes 2	No 3□Pro	obably 4 □Unknown
Ö	s beel	lete	SASCULAN C	lise FE	,	, ,	İ	V			24a. Was		24b. Were au	topsy findings available ompletion of cause of
Vital Records,	The la	Completed by									autor perfo	psy ormed2 2 No	prior to c death? 1 \( \sum \text{Yes}	ompletion of cause of 2□ No
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7	hysic this co	은	1 Yes 2 No			ER/Outpatier			4 🗆 Nu				Other (Spec	ity) to-pica
n C	ling F After funera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	ng ,	f Injury n, Day Year)	28b. Time o Injury	M 28	8c. Injury Work	rat :? Yes 2 □ I		28d. Describe	how injury	y occurred	1
Division or	death ctor: y the	icat	3 Suicide 6 Could		of injury - At ho	ome, farm, str			162 2 1		28f. Location /	Street and	d Number or Ru	ral Route Number,
Ω	after after I Dire	Certification:	4 ☐ Homicide determ	building	g, etc. (Specif)	y) .					City or To	wn, State)	)	
	ospita hours unera ily fille			ng Physician: To the b										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one)	and manne	er stated.								,	, ,
	with Con	2	29b. Signature and title of certific	1.0	in	O	290.	License	number			29d. Date	e signed (Month	1, Day, Year)
	1		If the	7/11	7 ·	. 00a\ /T	Drin*\	10	حص د	7		Jorn	001-)2	,, 200/
6	12		29b. Signature and title of certification.  30. Name and address of person.  31. Date filed (Month, Day, Year,	, GBMC	6701	(Type,	Cha	les.	St. B	elter	inne, 1	W	2120	>
	Sta	ate	31. Date filed (Month, Day, Year	) 32. Re	gistrar's Signa	ture	de s							
	Regist	rar	IAN 9 3	2007	sed to	No.	107.17							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #5 Per FH 6863 1729707 Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First\_Middle, Last) 2. Date of Death Month Day Year **Physician** 1:03 AM Kea 16, 2007 an /Medical Facility Name (If not institution) give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner ltimore lowson Mis 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Starity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F 217-87-0877 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No M) Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? F00+ Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Blac Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17-Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ seorge 10a. Informan Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau once. 5 21228 sville 20b. Place of Disposition (Name of cemetery crematory or other place) Method of Disposition 20c. Location - City or Town, State cemetery dematory or our .... 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 20-07 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service accessee 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mostry **Physician** 106/astoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) NOS Pier 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8303 6 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AA1 w 1 1 CHALLS W 6701 N. Charles T CHALLES Bathere no 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month mes e dan. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death give street and number) **Examiner** Baltimore Avenue Date of Birth (Month, Day, Year) If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X**M 2□F 9-28-Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. In 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 Wenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 SYOWN neodore 18a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any injury or other trau once. MD Z1207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic Funerall Services Ustown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Adenocarcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nabete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: funeral director, page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Natural injury 1 ☐ Yes 2 ∏No 2 ☐ Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marst 4924 White Doel 2. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Bradford 2007 a M January 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1535 Farlow Avenue Crofton Anne Arundel 5. Social Security Number 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🖫 F Months Days 309-30-0298 Director June 6 1931 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, ith Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1535 Farlow Avenue 21114 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 ₩ Widowed 4 □ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Van Conia Sherman 2 <u>Marie</u> Crook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven W. Bradford - son 215 Cape St. John Road, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 1/22/2007 Catonsville, MD 21. Signature of Funeral Service Licelston
Steven H. Willia 22. Name and Address of Facility Cremation Society of Maryland, Inc. H Williams M00986 **Physician** /Medical **Examiner** Physician/Medical Examiner physician and the burial-trans Division or Vital Records, P.O. Box 68760, use as been signed by the should be detached Completed by page 2 To Be nours after death.

neral Director: After this filled in by the funeral d Certification:

_	Steven II. WIIIIams 100,000   299	Hre	derick Road	Raltimo	re, MD 21	228					
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.		f dying, such as cardiac	or respiratory arrest,	10 1 11 41	Approx Interva	imate Between				
	Immediate Cause (Final disease or condition resulting in death)					Onset	and Death				
	Due to (or as a consequence of):										
	Det	26	to Carco	Dtom	1 0120	2	120				
	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events	LIVE		13							
	esulting in death) Last  Due to (or as a consequence of):										
	d										
	IF FEMALE: 23b Was decoded progress 23c. If yes, outcome pf pregnancy										
	23b. Was decedent pregnant in the past 12 months?  1 □ Yes ②X□ No 9 □ Unknown  23c. If yes, outcome pi pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ector 4 □ Pregnant at time of death 5 □ Othe	livery Day	Year								
	Part II. Other significant conditions contributing to death but not resulting in the underly	/ing caus	e given in Part I.	23e. Did tobac	o use contribute to	n the cause	of death?				
				1 ☐ Yes			Unknown				
				24a. Was an	24b. Were a	utopsv findi	ngs available				
				autopsy performed 1☐ Yes 2☐	?   death?	completion 2 □ No	ngs available of cause of				
	25. Was case referred to medical examiner?		26. Place of Deat	(Check only one)							
	Hospital	□ DOA	Other: 4 \sum Nursing Ho	me 5 🔀 Residence	e 6 □Other (Spe	ecify)					
	27. Manner of Death  1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M		Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred						
	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, farm, building, etc. (Specify)	actory, of	ffice	28f. Location (Stree City or Town, S	and Number or R	ural Route	Number,				
1	29a. Certifier Certifying Physician: To the best of my knowledge, death occur	urred at t	he time, date and place	and due to the same	-(a) and						
	(Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	jation, in	my opinion, death occur	red at the time, date	and place, and du	s stated. e to the cau	ise(s)				
	29b. Signature and title of certifier	29c. Li	cense number	29d.	Date signed (Moni	th, Day, Yea	ar)				
	) Junstice		(3155)	Ja	Incland 2	2, 2	007				
	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	Jel.	DINE (	F/0. 30	an Al	2100	31				
	31. Date filed (Month, Day, Year)  JAN 2 8 2007  32. Registrar's Signature	N. S. S. S. S. S. S. S. S. S. S. S. S. S.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		7 7 7 7						
	OR	RIGINA	AL.								

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State Registrar

		-	- For Amend #16a-b, per	State of Maryland FH, G864, 2/2/07	d / Depa TT <i>Cei</i>	artmen rtificat	t of Health a e of Death	ind Me	ntal Hyg	giene2 () () 7 Reg. No.	011	13
	Physicia	_	1. Decedent's Name (First, Middle, Last)  John Arthu					2	Date of Dea Month anuary	ith Day Year	3. Time of 8:25	Death P <sup>M</sup>
1	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or Location of	f Death	anaar_j_	4c. County of Dea	th	
			Laurel Regional 5. Social Security Number 6. Sex		ast hirthday)	If Under	Laure		. Date of Birt	Prince Geo	orge's	or Foreian
	Funeral Director			IM 2□F 61	Yrs.	Months		Min	ug. 9,	1945 Mar	y land	
	w.		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Lo	ocation					10d. Inside Ci	ty Limits
	Maryli Fied	tor	Florida Brevar	d In	dian H	larbo	ur Beach				1 ☐ Yes	2 🕅 No
	or 28	Funeral Directo	10e. Street and Number	"000		10f. Zip				10g. Citizen of What C	_	
	eeth w	eral	520 Palm Springs Bl	12. Was Decedent Ever in U.	S. 13.	Was Dece	32937 dent of Hispanic Drig city Cuban, Mexican	gin? (Spec	ify Yes or No	US. 14. Race - Am	erican Indian,	
98	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any fujury or other traumatic event, the Madical Examinar natal Landilled at once.	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 ★ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1	If Yes, spe 1 ☐ Yes		, Puerto Ri	ican, etc.)	Black, Whi	white	
Maryland 21215-0036	72 hour	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usu	al Occupation	of working	,	16b. Kind of Business Government		
121	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ASSOC	oo not u ciate	rk done during most se retired) Comput - Manager	ter Sc Engin	ience eer	In:	<del>surance</del>	-
9	Hygie other	Be Co	17. Father's Name (First, Middle, Last)	<del>-</del>						Maiden Sumame)		
ylar	should be ind Mental markad o umatic eve	ToE		ohm						ambert	77- 0- 4-1	
Mar	d 2 sh th and th and t7 ie m traum		19a. Informant's Name/Relationship <i>(Ty</i> Mr. Scott Blohm/Sor							er, City or Town, State, , Florida		
	ss 1 and of Health item 27		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ F	20b. P	lace of Dispo			Da		20c. Location - City o		
Baltimore,	Pages tment of tant: If it		4 ☐ Donation 5 ☐ Other (Specify)	Hil			ce Corp.			Towson, Ma		
Bal	permit. Departr Importu eny inju		21. Signature of Funeral Service Licens	1/ Rust			nd Address of Facilit ork Road	Nuc		on Funeral ryland 212		inc.
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the death							Approximat Interval Bet Onset and	tween
2	Physician		Immediate Cause (Final disease or condition resulting in death)	Atherosclero		ardio	vascular	Heart	Disea	se	Offiser and	
	/Medical Examiner			Due to (or as a conseq	uence of):							
	D ##	lner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b								
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):							
3760,	y s	cal		d	-							
x 68	ding ph	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancy					23d. Date of de	alivery	
Box	The law requires that the death certificate be executed site has been signed by the ettending physician and bage 2 should be deteched for use as the burial-transit	by Physician/Med	in the past 12 months?  1 \(\sum \text{Yes}  2 \sum \text{No} \)	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	□Ectopic p □ Other (s				Month	-	Year
P.0	that the ed by the detech	Phy	9 ☐ Unknown  Part II. Other significant conditions co		ulting in the u	underlying	cause given in Part I.		23e. Did t	obacco use contribute	lo the cause of	death?
rds,	quires tha in signed I uld be det								10	Yes 2□No 3□F	Probably 4 D	onknown
Records,	e law requir has been si je 2 should l	Completed							24a. Was autoj	an 24b. Were a prior to death?	autopsy findings completion of c	available cause of
		e Cor	25. Was case referred to medical				26 Place	of Doath	1 Yes	2 1 No 1 □ Ye	s 2 No	
$\leq$	Physician: this certific al director.	To Be	examiner?	lospital: 1   Inpatient 22	EP/Outpatie	nt 3□ D	Other			dence 6 □Other (Sp	ecity)	
0 UC	ing f		27. Manne of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of M	28c. Injury at Work? 1 ☐ Yes 2 ☐		8d. Describe	how injury occurred		
Division of Vital	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special					8f. Location ( City or To	Street and Number or I wn, State)	Ru <i>ral Route N</i> un	n <i>ber</i> ,
Ω	Hospital o		29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my kno	owledge, dea	th occurred	d at the time, date an	nd place, a	nd due to the	cause(s) and manner	as stated.	
	To the Mospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Usoical Exam	iner: On the basis of examina and manner stated.	ation and/or in	nvestigatio	n, in my opinion, dea	ath occurre	d at the time,	date and place, and do	ue to the cause(	s)
	To t To t	Σ	29b. Signature and title of certifier	10 + 0	<b>~</b>	29	c. License number	- an	7	29d. Date signed (Moi	IK 7	507
^	441		30. Name and address of person who d	ompleted cause of death (Iter	m 23a) (Type	, Print)	14000	7/	/	Mulay	10, 4	,0/
2	$U^{\dagger}$		solvator Sylv	est-er, 3001	H-50,	; tak	Drive	0	lover	MAY	/And	
	St Regist	ate rar	31. Date filed (Month, Day, Year) IAN 2 3 2007	32. Registrar's Signa	ature	Les .	,		•			

DHMH 17 Rev 1/2001

			For	State of Maryla				Mental Hygier	-	01111
		_	State Registrer		Cei	rtificate of	Death	Reg. I	No. UU/	U   4   4
	Physicia /Medic		1. Decedent's Name (First, Middle, Last Diaue	luse.	Brow	n		2. Date of Death Month	21 20c	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	street and number)	110	4b. City, Town,	or Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Se 152-28-9742	x 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye. 02-12-194	9. Bir 0 NE	thplace (State or Foreign ountry) W JERSEY
	/land		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	he Man 28a-f eh culled	ector		IMORE		GLEN	ARM	140-	C	1 □ Yes 2/CX/No
	h with t	급	4 WYTHE COURT			10f. Zip Code	21057	10g.	Citizen of What C	•
36	ges 1 end 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  X ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes YN No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 Yes 2000	Hispanic Origin? (S ean, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
5-00	72 hou neture	eted	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occu	pation during most of wor	rking 16b	. Kind of Business	Andustry
21215-0036	d within giene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) YEARS	life.	HOUSEWII	during most of word) -E		OWN HO	ME
Maryland	d be filed antal Hygi ad other	Be	17. Father's Name (First, Middle, Last)	CHARLES A.	GRIEBE			ne (First, Middle, Maid LORES VA		SEM
aryl	2 should be and Ment is marked	To	19a. Informant's Name/Relationship (7)	79.7				ral Route Number, Cit		
	1 end 2 Health a em 27 iu		CHRISTOPHER S. BRO				NG ROAD,	LUTHERVILL Date 20c		
Mor	Pages 1 ent of P nt: If ite ry or ot		20a. Method of Disposition  1 ☐ Burial 2 XX remation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		natory or other pla SERVICE (			. Location - City or OWSON , MAI	RYLAND, 21204
Baltimore,	permit. Pages Depertment of Important: If if eny injury or once.		21. Signature of Funeral Service Licens			Name and Addre		L HOME, INC	1050 Y • TOWSOI	YORK ROAD N,MD.21204
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused the d	eath. Do not ent	er the mode of dy	ng, such as cardiad	or respiratory arrest,		Approximate Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of):	Sower				Thous
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bb	sequence of):	<del></del>				
V_	te be executed ysicien and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):					
3760,		Cal	· ·	d						
Box 68	The law requires that the death certificate be executed with has been signed by the ettending physicien and bage 2 should be detached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Tetopia accessor			23d. Date of de	livery
P.O. B	that the death	ysicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of		Ectopic pregnand Other (specify)	у		Month	Day Year
	ires that signed b	by Pr	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobacc		o the cause of death?
Records,	w requir been si should	leted	Con Pulmuna	0 0				24a. Was an		
I Re		Completed by	Simular					autopsy performed	? death?	utopsy findings available completion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	G.E.D.O.	Ot	har	ith (Check only one)		
of	ng Phys ter this neral di	n: To	1 Yes 2 No '  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	IL JU DON	ry at	ome 5 Residence		ocify)
Division	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1	]Yes 2□No	29f Location /Street	and Minches on C	David March
Οį	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)			28f. Location (Street City or Town, St	ate)	
	To the Hospital or within 24 hours affer To the Funeral Dir. completely filled in I	Medical	29a. Certifier Check only one) Certifying Phy 2 Medical Exami	sicien: To the best of my iner: On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	4/	1	29c. Licen	se number	29d. 1	Date signed (Moni	th, Day, Year)
	00		raver le	Hursel.	(US)	DYC	744	Ja	nuary 2	1,2007
	$\mathcal{H}$		30. Name and address of person who o	ompleted cause of death (	tem 23a) (700) (C4) (700)	idral	Center	301 8	A Hour	A 20012
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 3 20	07 32. gisther's Si	gnature	me		- SUVII	w of w	y wiawa

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			1 - For State Registrar	State of I	Marylar				ealth a	ind M	lental Hyg	ienė () (	)7	01415
П	Physici	an	Decedent's Name (First, Middle,								2. Date of Deat Month		Year	3. Time of Death
	/Medic	al	Laverne [								January		oč <sup>a</sup> r	8:45 P M
	Examin	er	4a. Facility Name (If not institution, 16526 Greenmoun.		er)		4b. Cit		Location o			4c. County	_	.a
	Funeral				Age (In yrs.	last birthday)		er 1 Year	If Under		8. Date of Birth		Owar 9. Birthi	place (State or Foreign
	Director		297-24-5923	1 □ M 2020 F	78	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Jan 28,	1928	Pen	nsylvania
	D		Usual Residence of Decedent  10a, State 10b, County		10c Cit	ty, Town or Lo	cation							10d. Inside City Limits
	/anyia	ō	Maryland Howa	rd	100.00	y, 101111 of 20	oution	Flb	ridge					1 TyYes 2 □ No
	28a-	Director	10e. Street and Number				10f. Z	ip Code	rage		11	0g. Citizen of \	What Cou	ntry?
	death with the Maryland me 23a or 28a-f show count be myllfled at	ai Di	6526 Greenmoun	t Drive				210	75			τ	JSA	
	be filed within 72 hours after death with the Marylan Hygione.  do ther than "naturel", or iteme 23a or 28a-f show event, it a Madical Examinar must be multiled at	Funeral	11. Marital Status	12. Was Decede			Was Dec	edent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		e - Americk, White,	can Indian,
ရ	filed within 72 hours after Hygiene. other than "naturel", or ite ent, Ite Medical Examine	by Fu	1 Never Married 2 Married	d 1 ☐ Yes 2 If Yes, Give	<b>∑</b> No	1		2 <b>X</b> No	Specify:		,		» Bla	
15-003b	hour furei'	ed b	3 Widowed 4 Divorced  15. Decedent's	Year or Date	SS:	16a. Dece	ient's Us	ual Occup	ation			16b. Kind of B		
Ų	n na n na	Completed	(Specify only highest Elementary/Secondary (0-12)		05.5.1	(Give	kind of w		turing most	of worki	ing	TOD. TORIG OF D	33110334	duotry
7 7	d with	EOC	12th	College (1-4	01 3+)		D:	ìrect	or			Pr	ivat	e
	be file d oth event	Be	17. Father's Name (First, Middle, La	•							(First, Middle, A		ne)	
ylan	2 should be f and Mental h is marked of reumatic eve	<sup>L</sup>	Roland Willia			1 101 000					lotte Da	-		
Mar	d 2 sh sh and 7 is m treum		19a. Informant's Name/Relationship Carolyn Barne		r)		_				Route Number.			
d)	s 1 end 2 should if Health and Mer item 27 is marke other treumatic		20a. Method of Disposition	- (	20b. F	Place of Dispo	sition (N	ame of				20c. Location -		
ē	Pages ent of nt: If i		1 ☐ Burial 2 Tremation 3 4 ☐ Donation 5 ☐ Other (Spe		118	semetery, cirer esapeal			' 1	/17/	2007	Beltsv	rille	. MD
saltimore,	permit. Pages 1 Depertment of H Importent: If ite eny injury or ot once.		21. Signature of Funeral Service Li											ices, P.A.
מ	8958		Halricia	Stemore			5906	Kent	Town	Dri	ve, Land	dover M	ID 20	785
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau nly one cause on eac	sed the deat h line.	h. Do not ent	er the mo	de of dyin	g, such as	cardiac c	or respiratory arre	est.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a. Advan	ced de	ementia	a							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):								
		er	Sequentially list conditions,	b. Due to (or	as a cons	uence of								
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/pn,<	e exection and an arrial-tr	Exa	resulting in death) Last	Due to (or	as a conseq	luence of):								
9/2	death certificate be executed e ettending physicien and id for use as the burial-transit	dical		d									-	
٥ ×	eath certific ettending p I for use as	/Mec	IF FEMALE:	23c. If yes, outco	me of preen	ancy								
X Q Q	eath c etten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birtl 4 ☐ Pregnan	n 2 ☐ Feta	I death 3	Ectopic Other (	pregnancy				1	te of delive onth	ery Day Year
o.	that the de ed by the e detached f	nysi	1 ☐ Yes 2 █ <b>र</b> No 9 ☐ Unknown	9☐ Unknow			3 0 (.	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
ς, J	requires thet the een signed by th hould be detache	Completed by Physician/Me	Part II. Other significant condition	s contributing to deal	h but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did tob	acco use cont	tribute to t	he cause of death?
cord	w require been sig should b	ed t	HIN								1 ☐ Ye	s 2/2 No	3 Prot	oably 4 □Unknown
ته	> 0 0	piet	Anemia								24a. Was ar	n 24b.	Were auto	opsy findings available impletion of cause of
ř =	The lav	Соп									perform 1 ☐ Yes 2	ned?	death? 1 ☐ Yes	
VItal	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	20		Check only one			
5	Phys rthis ral dii	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Unp		ER/Outpatier 28b. Time of			4 🗀 140		me 5 Reside 28d. Describe ho			(y)
0	Attending P	tion	1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month,	Day Year)	Injury	М	28c. Injury Work 1 🔲	<br Yes 2 ☐ !	ĺ		,,		
Division	<b>⋖</b> ⊑ <b>6</b> 6	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of	Injury - At h	ome, farm, str	eet, facto	ry, office			28f. Location (Str City or Town		per or Rura	al Route Number,
ב	rs effe et Dir	Cert	4 E Frontiedo	Dulluling	, etc. (Specia	·¥/					ON O 1040	, 3(4)		
	e Hospitel ( 124 hours el Eunerel D letely filled i	edicai	(Check only 2 Medical E:	Physician: To the be caminer: On the basi	is of examina									
	within 24 within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manne	r stated.	<del></del>		9c. License				9d. Date signe		
	E 2 E 3		Signal of the trial of social of	3/4					) 63	608	34	1/1-	7/0	7
	^		30. Name and address of person w	ho completed cause	of death (Iter	n 23a) (Type.	Daine					· / [	1/0	1
	1		Arit Kurup-1.5	-Roesler	ROLE	ilen	BUY	nic	, M	d:	21060			
	Sta		31. Date filed (Mortin Day, Year)	2007 32 100	istrar's Signa	ature								
	Registi	ar	7. 0		the all the	IN RIA	CAN'S A	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Clara R. Brady January 2007 4:56 A. 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harbor Hospital Center Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 2, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗑 F 218 26 4961 Yrs. Director 81 Bermuda Usual Residence of Decedent with the Maryland 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits If item 27 is marked other then "neturel", or items 23s or 28e-f show or other treumetic event, the Medical Evantual must be notified at Director Maryland Anne Arundel 1 ☐ Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5715 Magie Street 21225 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other then ' Elementary/Secondary (0-12) Secretary Chemical Company years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Augustus Terceira Rose Baptist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Brady Sr. / Husband 5715 Magie Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or State Veteran Cem. 1/23/2007 \* 4 ☐ Donation \_5 ☐ Other (Specify) Crownsville, Maryland 21. Signature of Ameral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition 6 month /Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No 9☐ Unknown s been signed by the should be detached 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy perform certificate 2**X** No 1 🗌 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 Tes 2 No 3X DOA 1 Inpatient 2 ER/Outpatient this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury investigation 1 Yes 2 No Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D17743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001. S. HANOVER ST, Suite 108, BALTO, SEENIVASAN JAN2 3 31. Date filed (Month, gistrar's Signature State 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 15 Clara Leah Cohen Drugh 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 4c And Mehabilitati 001 Date of Birth (Month, Day 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Months Days Hours (Month, Day, Year) 10/6/1922 84 192-14-5144 Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD Harford 1 ☐ Yes 2 No Funeral Director Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a 2900 Auden Court 21009 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White XVidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F ပ Percy R. Peck Leah Morrough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a William Peck - Son 2900 Auden Ct. Abingdon, other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. anuar 1 ☐ Burial \*\* Cremation 3 ☐ Removal from State 19, 4 ☐ Donation 2007 Forest Hill, MD 5 Other (Specify) Funeral Service License 22. Name and Address of Facility Evans Funeral 3 Newport Dr. Forest Hill 21050 Chapel And Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes performed 2 No 2 0 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 20 NO Certification: To 1 🗌 Yes 1 ☐ Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1∏Yes 2 No after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Manne

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

			_ 101	artment of Health and Men	ıtal Hygien	e 2007	011.19
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. N	lo.f- U U /	U 1 4 1 0
ı	Physicia					2007 Year	3. Time of Death 12:00 PM
700	/Medic		Kathleen A. Cahill  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		Ic. County of Death	12.00 F
	Examin	er	1001 Adcock Road	Lutherville			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8, [	Date of Birth (Month, Day, Yea	Baltimore 9. Birthp	place (State or Foreign
ь	Director		213-36-9069 1□ M 2\ F 67 Yrs.			1939 Mary	land
	w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation		11	0d. Inside City Limits
	Maryla f sho	ō	MD Baltimore Luthervi	110			1 ∐Yes 2 ⊠No
	the last	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Cour	ntry?
	h with		1001 Adcock Road	21093		USA	
	ems 2	Funeral		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - Americ Black, White,	
စ္တ	or its	F	1 Never Married 2 Married 1 Yes 2X No	1 ☐ Yes 2 ☐ XNo Specify:		Specify:	
8	filed within 72 hours after death with the Maryland Hygiene. Ather than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at	d by	3 ➡Widowed 4 ☐ Divorced Year or Dates:	whi		Wn	ite
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	~= 0 2	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fir			
<u>la</u>	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Manatic event, the Manatic event.	10	William H. Witt	Margaret	Burns		
Maryland	2 sho			ing Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip	Code)
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Baltimore,	ages nt of h		I Buriai 2 Lacremation 3 Linemoval from State	ematory or other place)		•	
를	artme artme ortani injun	1	4 □ Donation 5 □ Other (Specify) Metro Ci 21. Signature of Funeral Service Licensee	*		altimore,	MD _
a	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		1/100 100 - 10 1	r Name and Address of Facility Tremation Society of 199 Frederick Road Ba	Marylan 1timoro	d, Inc.	Q
46	4 2		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			<u>, MD 2122</u>	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	ic Gerebouwal	Dil	Cell	Onset and Death
di.	/Medical	İ	resulting in death)  Due to (or as a consequence of):		~ ~		2
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				9
	execu al-tra	xan	that initiated events resulting in death) Last C Due to (or as a consequence of):				
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99	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medi	IF FEMALE.		-		
Box 6	death certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delive	ery Day Year
	ne dea the at hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)	· · · · · · ·	Month	Day real
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Records,	uires signe Id be	d by	Malabsorptin			1	pably 4 □Unknown
S	w req	lete	COPD		24a. Was an	24h. Were auto	ppsy findings available
8	The law te has l age 2 s	Completed			autopsy performed?	prior to co death?	mpletion of cause of
ţ	lan: Triffica	Be C	25. Was case referred to medical	26. Place of Death (CI	1⊡ Yes 2 🔼 t heck only one)	No 1 ☐ Yes	2 No
<u>r</u> <	Attending Physician: r death. ector: After this certific by the funeral director,	ToE	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing Home	5 Residence	6 □Other (Specif	(y)
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Division or Vital	lor A after o Direction by	Certification:	4 ☐ Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	reet, ractory, office	City or Town, Sta	a <i>nd Number</i> o <i>r Rura</i> ate)	ar Houte Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, and	due to the cause	(s) and manner as s	itated.
	he Ho n 24 l he Fu pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred a	at the time, date a	and place, and due t	o the cause(s)
	Tot Tot	Σ	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month,	
				019453		1/22/0	/
	7		30. Name and address of person who completed cause of death (Item 23a) (Typ. Dr. Edward Miller 5601 Loch Raven Bl	VD Baltimore, MD 212	239		
	Sto	te	31. Date filed (Month, Day, Year)  JAN 2 3 2007	and the second			
	316		10007 1000				

DHMH 17 Rev 1/2001

07-00487 Linda Colbert

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

inda Colbert		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2007 0 4
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last)  Linda Colbert  2. Date of Death Month Day Year January 18, 2007  3. Time of Death 1015 hrs
		4a. Facility Name (if not institution, give street and number)  11 W. 20th Street, Apt. 13C  4b. City, Town, or Location of Death Baltimore  4c. County of Death A. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Alak Grade (State o
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits
* J	ō	Md. NA Baltimore 1 XYes 2 No
th the Maryland 23a or 28a-f she	Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  11 VI 20 th Street and Number
ath with the items 23a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Indian, Black, Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 8 Married 8 Married 8 Married 8 Married 8 Married 8 Married 9 Married 8 Married 9 Marri
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6 172 hour an "natu cal Exan	leted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	Complete	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
10re, MD 21215-0036 siges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene t: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner missis be notified at once	ro Be	Charles Colbert  19a Informan's Name/Relationship (Type, Print) a shter)  19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
Md 2 alth gard and 2 aum		MS. Latasha Smith 4009 White Ave, Batto, Md. 21206  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:  1/24/2007 Lansdowne, Md. 21 Street and Specify:
Baltimo permit. Page Department Important: injury or out		21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Seph. L. Russ Funeral Home, P.A.
Physician /Medical		23a Part I Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and
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and the second	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause
ited d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	Medical	X UNPENDED #23a,PII,27,28a-f, perME, g863, 1/31/07 TT
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
5 ½ £ 8	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
		30 Name and address of person who completed cause of death (Item 23a)  O.C.M.E. January 19, 2007
	ate	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Pay Year) 32. Redistrar's Signature
Regis	trar	31. Date filed (Month, Ray Year) 3 2007 32. Re Istrar's Signature

		•	1- State of Maryland Dep State of Maryland Dep 1- State of Maryland Dep 1-31/0Ce	artment of Health and M TH Inficate of Death	ental Hygien	2007 01420
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	/Medic			ampbell	ponuary	21 2007 510 PM
	Examin		4a. Facility Name (If not institution, give street and number) 44 Reeds Run Road	4b. City, Town, or Location of Death Edgewood		tc. County of Death Harford
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 62 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea May 27, 194	9. Birthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		10d. Inside City Limits
	Mary -f sh	ģ	Maryland Harford Edgew	<i>r</i> ood		1 ☐ Yes 2 ☐ No
	r 288	Director	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Country?
	ith wit	aiD	44 Reeds Run Road	21040		USA
36	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.  I is marked other than "natural; or itema 23a or 28a-f show raumatle event, the Medical Examinat must be notified at	by Funerai	1 Never Married AMMarried Armed Forces?  1 XYes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	ocify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Tab. + C
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	os 1 and 2 sh of Health and I Item 27 Is m r other traum			ing Address (Street and Number or Rura Mauser Drive, Bel		
Baltimore,	nit. Pages 1 and 2 should artment of Health and Mer ortant: If Item 27 is marke injury or other traumatic B.		20a. Method of Disposition  1 \textbf{\fightar}\ Burial 2 \subseteq Cremation 3 \subseteq Removal from State \\ \(^1\) \text{\fightar}\ Holly \(^1\) Hi	osition (Name of matory or other place) 1 Memorial 25, 2		Location - City or Town, State  ddle River, MD.
Baltii	permit. Pages Department of Important: If I any injury or one		21. Signature of Funeral Service Licensee	me Of Dun	dalk.P.A.	
	10000		23a. Part 1. Enter the disease, or complications that caused the death. Do not a	110 Sollers Point at the mode of dying, such as cardiac o		Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	¿ Cardio Varcul	0. 11:	Interval Between Onset and Death
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Вох	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	Destrois		23d. Date of delivery
	ne deatl the atte	Physician/Me		□Ectopic pregnancy □ Other (specify)		Month Day Year
P.0	that the de ed by the detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobacco	o use contribute to the cause of death?
Records,	sign d be	ted by	Multiple sclerosis		1 🗆 Yas	1.0
Reco	ne law requ i has been ge 2 shoul	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital			25. Was case referred to medical	OC Plans of Posth	1 Yes 2	
5	Physician: this certific ral director,	o Be	examiner?  1X Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death	1	6 □Other (Specify)
n of		lon: T	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  Injury Injury	of 28c. Injury at Work?	28d. Describe how in	
Division	or Attendiater death. Director: A	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location (Street	and Number or Rural Route Number.
Div	rs after al Direc ed in by	Certification:	4 Homicide determined 226. Place of injury * At nome, farm, s	neet, ractory, onice	City or Town, Sta	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	in occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the To the Comp	M	29b. Signature and title of solifies	29c. License number	29d. I	Date signed (Month, Day, Year)
,	701		Jonal J. With MO DIME	HC014206	b	uray 21, 2007
	1		30. Name and address of pirson, no completed cause of heath (Item 23a) (Type BEKMAD) J. YUKNA, MUJME 16/4	CHURCHVILLE RJ	BELAI	R Md 21015
	Sta Regist		31. Date filed (Month, Day, Year)  JAN 2 3 2007  32. Segistrar's Signature	basis		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** JESSIE 1:20 1007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MI) BON SECOURS HOSPITAL 21733 If Under 1 Year | If Under 24 Hrs. 6 Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Director 84 246–18–3527 07/30/1922 NC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at Director 1 Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or "natural", or items 23a or 708 N. MONROE ST 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the SCAFFLER CONSTRUCTION marked other alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ LONNIE COX MYRA HAMLIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau FOREST HAMLIN/NEPHEW 10012 FALLRAIN DR., LAUREL, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location City of Town State ST. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY CEMETERY 01/19/2007 BALTIMORE, MD 21224 21. Signature of Funeral Service Livense 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. na 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE RESPIRATORY /Medical Due to (or as a consequence of): **Examiner** PUL MUNARI EM MO LISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit be executed DEEP VENOUS THROM BOSIS Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ ATMAL FIGRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed OBST RUCTIVE PULMONARY DISEASE CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No DIVERTICALAR MEEDING (DUTIS 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: cal or Attendurs after death.

Aeral Director: A

ity filled in by the 1 Natural 5 ☐ Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DIRNET V. WOEH BELL, MD 2007

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 2 3 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000. BANTIMOREST., BALTIMORE, MD 2023

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANOARY Pay, 2012/7 3:30 AM Caroline Theresa Connolly /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Center Towson If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Aug. 7, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** <sup>Year)</sup> 1918 1 □ M 2 🔽 F Yrs Aug. 214-14-8660 88 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 E. Joppa Road 21286 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No ò Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Archdiocese of Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than Baltimore Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Harry T. Connolly Marguerite Kram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Jim Connolly brother 1111 Green Acre Road; Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation ♠ □ Other (Specify) New Cathedral Cem. 1/24/07 Baltimore, MD 21. Signature of Fune of Service Licens 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one hause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK **Physician** /Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dur to for as a consequence offphysician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Se IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 25 No Month 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPOXIA 1 Yes 2 No 3 Probably 4 Wunknown 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No HYPOTHERMIA 24a. Was an has certificate ha autopsy performe 1∐ Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ٩ 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760. Division or Vital Records,

Hospital or AttendIng Physician: s after death.

I Director: A

d in by the fu within 24 hours at To the Funeral Completely filled in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON POH LIM, M. D. 31. Date filed (Month, Day, Year) State

4 Homicide

(Check only one)

29b. Signature and title of certifier

2007

29a. Certifier

Medical



Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D37254

TOWSON.

MARYLAND

29d. Date signed (Month. Dav. Year)

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Gregory William C		vert I- For State	Sta	te of Maryl		partment of Certificate of		nd Mental	Hygiene	0.0	
Physician		Registrar 1. Decedent's Name	First, Middle,	Last)		oranouto or	Doutin		2. Date of De		3. Time of Death
Medical Examine	er	Gregory 4a. Facility Name (if		m Calver			1. 01. 7		Month January		1040 nrs
		122 Orthoric		give sheet and it	umber)	1	b. City, Town, o Lutherville		eatn	4c. County of Baltimore	
Funeral	T	5. Social Security N	umber 6	i. Sex	7. Age (In y	rs. last birthday)	If Under 1 Ye			lirth(MM/DD/YYYY)	9. Birthplace (State or
Director		218-68-9		1 M 2 F	50	Yrs	Months Da	ys Hours	Min. Dune 1	5, 1956	Foreign Country) MD
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arylan	Ulrector	10e. Street and Nun					10f. Zip Code			10g. Citizen of Wha	
the M	<u> </u>	122 Oth	oridge	Road			21093			USA	
h with	ᇙᅡ	11. Marital Status			cedent Ever in	n U.S. 13. Wa	s Decedent of H	ispanic Origin?	( Specify Yes or N		American Indian, Black,
or ite	Funeral	1 Never Marrie		1 Yes	2 Y N		es, specify Cuba		erto Rican, etc.)	White,	etc.
rs afte ural", miner	≥ -	3 Widowed  15. Decedent's Ed		ced If Yes, Give Ye or Dates:		1 16a Deceden	Yes 2 X N t's Usual Occupa	o specify:	of work dono	Specify:	White
72 hou	Completed	Elementary/Seco			1-4 or 5+)		ost of working lif	e. DO NOT use	retired)	16b. Kind of Bus	,
036 eithin ane. rrthar	ᇍ	12				Оωг	ner			Carpe	
21215-0036 Muld be filed within 7 Mental Hygiene in marked other than c event, the Medica		17 Father's Name (		,			-	18. Mother's Na	ame (First, Middle,	Maiden Surname)	
121 Id be f Aental narkee	e P	James W.  19a. Informant's Nai				105 Mailine	Address (O)		tafford		
Baltimore, MD 21215-0036  permit Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "matural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at once.	-	Joan Calv							or Rural Route Ni 'e Timoni	ımber, City or Town	, State, Zip Code) 21 093
e, N I and Health item	- 1	20a. Method of Disp	position			b. Place of Dispos	ition (Name of ce	emetery.	Date		City or Town, State
MOr Pages ent of nt: If		1 Burial 2 4 Ponation 5	_			Crematory or oth	, ,		1/26/07	Timoniu	ım. MD.
Baltimore, permit Pages I an Department of Hea Important: If ites injury or other transitions.	F	21. Synature of Fur				Dulaney \	ame and Addres	ss of Facility	uck Tows		al Home, Inc.
	4	supl &	7 6			1105	iO York	Road. T	nuson Ma	ryland	21204
Physician /Medical		23a, Part I. Enter the failure. List onl	a disease, or co y one cause or	n each line.			ne mode of dying	, such as cardia	ac or respiratory ar	rest, shock, or hear	t Approximate Interval Between Onset and
Examiner		Immediate Cause (For condition resulting		a. Contact G		ound of Head					Death
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	e e	if any, leading to im cause Enter Under	mediate	Due to (or as	a consequenc	pe of):					
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Box 68766  ne death certificate  r the attending phy hed for use as the b		IF FEMALE. 23b. Was decedent p	pregnant in the	23c. If yes,	outcome of p		al death 3	Ectopic pre	anancy	23d. Date of o	
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sion ttendi death ctor:	a10	1 Natural 2 Accident	5 Pendin Investig	9 1 04	): Day, Year) 2007	FOUND: 1020 hrs	1	Yes 2 🗸 No	Subject sho	ot seir	
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bou hou y fill		4 Homicide 29a Certifier		(0,000.1)	Single F						ville Timonium, MD
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	اق	(Check only	Medical Exami	iner: On the basis	of examinatio	rledge, death occur on and/or investigat	red at the time, on, in my opinion	date and place, a n, death occurre	and due to the cau ed at the time, date	se(s) and manner a and place, and du	e to the cause(s)
	ğ	29b. Signature and	title of certifier	and manner:	stated		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
		(0	traf	HA	l Qa		O.C	M.E.		January 22,	2007
10	h	30. Name and addre				,					
[0]		Carol Allan,		stant Medical	Examiner egistrar's Sigr		Street, Baltim	nore, MD 21:	201		
Stat Registra	ce ar	31. Date filed (Monti	IN 2 3	2007	egisual s oigr	A Apa	elis.				

DHMH 17 Rev 1/2001

			For State Registrar		State	of Mary	/land /		artment of I			ental Hy	gien Reg. N	1001	0		24
			1. Decedent's Name (First, M.	ddle, Las	t)							2. Date of De	ath			3. Time of	Death
	ıysicia Medic		MARGARE	T	ELIZI	ABET	n+ c	140	UIWAR	Ø	].	JAN	22	ay Yea	7 5	5:45	AM
	kamin		4a. Facility Name (If not institu						4b. City, Town,	or Location	n of Death		4	c. County of De	ath		
<b>L</b> .,			5704 CAR						ELDER					CARR			
	neral ector		5. Social Security Number 216 03 6773	6. Se	ex □ M 2 <b>)2</b> 0 F		n yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da NOV 2	ıy, Yeai	r) (	Country)	e (State o	-
and	-		Usual Residence of Decedent 10a. State 10b. Cou	nty		10	C. City, Tov	vn or Lo	ocation						10d.	Inside Cit	ty Limits
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r dea	EL DI	Iner	11. Marital Status		12. Was Dec Armed F	orces?	r in U.S.	13.	Was Decedent of If Yes, specify Cut	Hispanic C ban, Mexica	Origin? (Spec	cify Yes or No Rican, etc.)	)-	14. Race - Ar Black, W			
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	or other traumatic event, the Medical Examiner must be notified at	d by Funeral Director	1 Never Married 2 Never Married 2 Never Married 2 Never Married 2		1 🗌 Yes If Yes, G Year or I	2 No live Dates:			1 ☐ Yes 2 🕱 No					Cassifu		ITE	-
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or He	ts di		20a. Method of Disposition 1   Burial 2 □ Cremati	. 2 🗆	Pomoval from	State	remete	on cra	matary or other of:	arel I							3
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Baltimore, permit. Pages 1 and Department of Heall mondant. If them?	any injury once.		21. Signature of Funeral Serv		m Sru			23	2. Name and Addr	ress of Faci	ility JN	ZUMB	wa	1FH & 1	now	10.	
		-	23a. Part1 Enter the disease			caused the	death Do		028 SYI					JCG-, MX		proximate	
			shock, or heart failure.	ist only	one cause on	each line.	doain. Do	not an	ier the mode or dy	ning, such a	as cardiac or	respiratory a	11031,		Int	terval Bety set and D	ween
Physi /Med	ician dical		disease or condition resulting in death)	-	a. Due to	ardia	onsequence	40	yren								
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. Box 68760, death certificate be executed	the burial-transit		resulting in death) Last	-	Due to	o (or as a co	onsequence	of):									
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oentific	for use as	/Me	IF FEMALE:		23c. If yes, or	utcome of p	oregnancy							23d. Date of c	tolings.		
Box leath cer	for u	ciar	23b. Was decedent pregnant in the past 12 months?		1 ☐ Live		Fetal deat		Ectopic pregnance Other (specify)	су			ĺ	Month Month	Da	y Y	'ear
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	should be det	by P	Part II. Other significant con	ditions c	ontributing to	death but n	ot resulting	in the u	nderlying cause g	oven in Part	tl.	23e. Did	obacco	use contribute	to the c	ause of d	eath?
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Phys	2 '5	. To	1 Yes 2 No		28a. Date	Inpatient of Injury	2 ER/O	utpatie	" OF DOX		Nursing Hor	ne 5 🗶 Resi 8d. Describe		6 Other (S)	pecify)		
	<u> </u>	tion	1 Natural 5 ☐ Pe	nding estigation	(Mo	nth, Day Ye	ear)	Injury	Wo	ork? ☐Yes 2.		od. Describe	now in	ury occurred			
Division or Attending after death.	y the	fica	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e, Plac	ce of Injury	- At home, f	arm, st	reet, factory, office					and Number or	Rural Ro	ou <i>t</i> e Numi	ber,
<b>5</b> 5 8 8	din	Certification:	4  Homicide de	emmed	buile	ding, etc. (	Specify)		NIA		- 1	City or To	wn, Sta	te)			
Hospital of Pours a	completely filled in by		29a. Certifier Cert	fying Ph	ysician: To the	ne best of n	ny knowledg	je, deat	h occurred at the	time, date a	and place, a	nd due to the	cause(	s) and manner	as state	d.	
To the H within 24	plete	edical	one)		and ma	nner stated	i.	na/or in	vestigation, in my			d at the time,					) 
5 ¥ ₹	2 63	Σ	29b. Signature and title of cer	tifier 1	100	0			29c. Licer	nse number	$\frac{1}{2}$	(1)	29d. D	ate signed (Mo	nth, Dey	(, Year)	7
1	/		30. Name and address of per	son who	completed car	use of deat	h (Item 23a)	(Type	Print)	02	1 (1	U		1 dd	10	YU(	UT
1	0		6190 Geo	100	tou ~	, Bl		E	Keibin	r M	0 3	KLIZ	4	-	•		
	Sta	1.5	31. Date filod (Month, Day, Y		324	strar's	Signature		9-0-	,							
*	egistr		JAN 2	3 2	007	Refere.	1. 18	A	1247								
DHMH 17	nev 1/20	JU1					ORI	GIN	AL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARY ELLEN CLEMENTS /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** SIMAL HOSPITAL OF BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🙀 F 220-24-8728 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County r 28a-f shov notified at Director Maryland N/A

124 South Ellwood Avenue

15. Decedent's Education (Specify only highest grade completed)

Joseph Patrick Oates, Esq.

1 ☐ Burial 2 XCremation 3 ☐ Removal from State

10e. Street and Number

1 Never Married 2 Married

3 ☐ Widowed 4 X Divorced

Elementary/Secondary (0-12)

Unknown

17. Father's Name (First, Middle, Last)

Joseph

4 □ Donation 5 □ Other (Specify)

11. Marital Status

4b. City, Town, or Location of Deat BALTIMORE

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Days

	Reg	. NO.		
	2. Date of Death Month	Day	Year 2007	3. Time of Death
h		4c. Cour	nty of Death	
<	-174		N/	A

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 26, 1 Birthplace (State or Foreign Country) Hours

Maryland 10d. Inside City Limits 1 Yes 2 No

Baltimore City 10f. Zip Code 10g. Citizen of What Country? 21224

USA 14. Race - American Indian, Black, White, etc.

(Unknown)

20c. Location - City or Town, State

1 ☐ Yes 2 X No Specify: White Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Homemaker Own Residence

> 18. Mother's Name (First, Middle, Maiden Surname) Nellie

19a. Informant's Name/Relationship (Type. Print) (Per.Rep) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Walther Blvd, #2317, Parkville, MD 21234

20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery 1/26/2007 Baltimore, Maryland

22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC.

21. Signatur | Fur al Service per eawson

Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximate shock, or heart failure. List only one cause on each line. CONGESTIVE HEART FAILURE

Immediate Cause (Final disease or condition resulting in death)

in the past 12 months? 1 ☐ Yes 2 ☑ No

9 Unknown

Sequentially list conditions, if they reading to include a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

20a. Method of Disposition

Due to (or as a consequence of):

**Clements** 

Dual to (or as a nonsequence of):

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

Due to (or as a consequence of):

23b. Was decedent pregnant

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

FIBRILLATION

HYPERTENSION

STAS15 26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a Was an 1☐ Yes 2☐ No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

VENOUS 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ ₩6 27. Manner of Death 1 → Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 Pending

investigation 6 Could not be determined

Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

OF BARTIMORE

29a. Certifier (Check only one)

1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

m.D

Rts -000

HOSPITAL

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOULMAN LAWAL

31. Date filed (Month, Day, Year)

JAN 2 3 2

SIMM m. 1) Pegistrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

"natural", or items 23a or

other traumatic event, the

marked other

permit. Pages
Department of
Important: If it
any Injury or o

/Medical

physician

ed by the a

page certificate

funeral director,

the

After this

or Attending

death.

within 24 hours after death To the Funeral Director:

. Pages 1 and 2 should be fill thent of Health and Mental Hitant; If item 27 is marked oth

Funeral

Completed by

Be

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Examiner

Physician/Medical

à

Completed

Be

၉

Certification:

Medical

State Registrar

Physician Examiner P.O. Box 68760, Division or Vital Records,

certificate be executed

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 21, 2007 10:20am **Physician** Dacre Carmella anyary Rose /Medical 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Oseda Year If Under 8. Date of Birth (Month, Day, Year) April 17,1916 Birthplace (State or Foreign Country) Social Security Number yrs. last birthday) **Funeral** Days Hours Min 1□M 2⊠F 215-09-9482 Yrs. 90 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show item 27 ie marked other than "natural", or itema 23a or 28a-f ehov other treumatic evant, it e Madical Examinal must be notified at 1 Yes 2 No Baltimore Nottingham Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 12 Tilton Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 ☐ Divorced iiit. Pages 1 and 2 should be filed within 72 hours arment of Heelth and Mental Hygiene. ortant: if Item 27 ie marked other then "netural", njury or other treumatic event, ILE Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Optic Graphics Book Binder 6 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carmella Donafo Dominic Piccione 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 Tilton Court, Nottingham, Maryland 21236 Shirley A. Bell Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Holy Redeemer Department of Important: if any injury or once. 24, 2007 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Connelly Funeral Home Of Dundalk, P. 17110 Sollers Point Road, Dundalk, Md. permit. P.A. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) weeks **Physician** rneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of). by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-translt veekand P.O. Box 68760, ears IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۾ 4 Homicide To the Hospitel of within 24 hours all To the Funeral Completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 of death (Item 23a) (Type, Print) completed cause Name and address of p Franklin Square 32 gegistra 's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1 Year Day **Physician** 7:24P M 18 2007 Antonina Frances Duva11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Baltimore Washington Medical Ctr <u> Anne Arundel</u> 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/3/1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Yrs. 76 Director 216-24-8769 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or itema 23a or 28a-f ehow tre Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No MD Glen Burnie Director Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1108 Cedarcliffe Drive 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify. white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry jes 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 ie marked other then "n or other traumatic event, It a Med Elementary/Secondary (0-12) College (1-4or 5+) Home Owner Home maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Gianforte 2 Rosario Zito 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if item 27 1108 Cedarcliffe Dr., Glen Burnie MD 21060 Mr. M. Clark Duvall/spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State ö Department of important: If any injury or once. Glen Burnie MD 4 □ Donation 5 □ Other (Specify) Glen Haven Cemetery 1/22/2007 1. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that cause I the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a convequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ significant conditions contribuling to death but not resulting in the underlying dause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe certificete 2X No 1 Yes After this certific funeral director, 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one)

TONINA

31. Date filed (Month, Day, State Registrar

30. Name and

29b. Signature and title of certifier

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Pring

29c. License numbe

29d. Date signed (Month, Dey, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month William H. Everngam, Jr. January 16, 2007 1445 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 2, 191 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1X M 2□ F Yrs. 217-14-9237 90 Mary1and 1916 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County Montgomery Maryland 1 ☐Yes 2 TNO Director Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 20816 United States 5101 River Road, Apartment 302 Funeral ırai", or items ? I Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1⊠Yes 2□No World If Yes, Give Year or Dates: War II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than ' Elementary/Secondary (0-12) College (1-4or 5+) Business Man Trade Assocation 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) William H. Everngam Edna Calendar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1824 Deer Drive, McClean, Virginia 22101 Jon Everngam / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 1 Burial 2 □ Cremation 3 □ Removal from State Greenmount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22, 2007 Baltimore, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Case Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause first U dentity Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No for Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Pneumonia 1 Tes 2 No 3 Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 1 Yes 2 No ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a

To the Funeral I

completely filled Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) January 19, 2007 D008011 MD ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Eric Park M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814

Registrar

State

JAN 2 3 2007

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician January 18, 2007 Gladys A. Edwards 1:26 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 9. Birthplace Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) e (State or Foreign **Funeral** Days Hours 1 □ M 2 🛛 F 228-16-9448 85 Director January 18, 1922 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Montgomery Montgomery Village 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 19310 Club House Road 20886 Apt. 305 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 Widowed 4 □ Divorced the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bookkeeping Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, ± 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ပ George Lee Louie Belle Van Pelt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julian Dwight Edwards, Jr./son 2929 Mother Well Court, Herndon, VA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 22. Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2007 Rockville, Maryland 21. Signature of Funeral Service Licens Robert A. Punphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 any In Willian M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Bleeding Immediate Cause (Final **Physician** rebrat day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 🗷 No Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a, Was an page 2 certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I 29b. Signature and ittle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2007

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31. Date filed (Month, Day, Year)

D053654

9901 Medial CenterDrive, Roycille, MD 20850

			1 - For State Registrar		aryland / Depa		Health and	Mental Hy	_	7 01430
1	Physici	an.	1. Decedent's Name (First, Middle, Las	1)				2. Date of De	ath Day Yea	3. Time of Death
46	/Medic		MILDRED JUNE FLETCHE					JANUARY		1630 P M
1	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	th	4c. County of D	eath
4			1019 MINNETONKA RD. 5. Social Security Number 6. Se	7 Ag	/ / for use foot high day	GLEN BUR		C Data of Bird	ANNE ARUN	
301	Funeral Director		220.12.4779	M 2 F	e (In yrs. last birthday)  Yrs.	Months Days			y, Year) 1925	Birthptace (State or Foreign Country) MD
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -feh	to	MD ANNE ARUND	EI.	GLEN BURNIE					1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Whal	
	th wit	aiD	56 FORESTDALE AVE.			21061			USA	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	10	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2XX No	Hispanic Origin? (S ban, Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)	Specify:	merican Indian, hite, etc.
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121	within 308. Ithen	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retir	ed)		ONN HOME	
2	filed v Hygie ther i	ပိ	12 17. Father's Name (First, Middle, Last)		F	HOME MAKER	18. Mother's Na	me (First Middle	OWN HOME Maiden Sumame)	
an	Mental Mental arked o	To Be	ELMER T. NEISSER				MARY C.	•	,	
Maryland	and M and M is mar	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Stree		and the same of th	r, City or Town, State	a, Zip Code)
	and 2 fealth a m 27 ls		EARL THOMAS FLETCHER	HUSBA	AND 56 F	ORESTDALE	AVE. GLEN	BURNIE, MD	21061	
Ore	of He of He fiter		20a. Method of Disposition  XXX Burial 2 Cremation 3	Romoval from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other pl	ace)	Date	20c. Location - City	or Town, State
Ë	nit. Pag sartment ortant: I Injury o		4 Donation 5 Other (Specify		GLEN HAVEN	CEMETERY	JAN	23, 2007	GLEN BURN	IE, MD
Baltimore,	permit. Page Department of Important: If any Injury or		21. Signatur Funeral Service Ca.  K. CRECOFF FIRK	the			ress of Facility _ HOME, P.A YY S. GLEN 1		21061	
25c			23a. Part Enter the disease, as mp	lications that caused ine cause on each lin	the death. Do not ent	er the mode of dy	ring, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
* "	Physician		Immediate Suse (Final disease or condition	2	Athe	OSCIE	1051)			Many years
- Magili	/Medical Examiner		resulting in dealth)	Due to (or as	a consequence of):	<u> </u>		<del></del>		1,000
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P.O. Box	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 21X No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnant Other (specify)	су		23d. Date of o Month	delivery Day Year
	res that igned t be det	by P	Part II. Other significant conditions co	ntributing to death bu	If not resulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use confribute	to the cause of death?
Records,	w require been sig should b	edt	Remote SN	olling	Conse	STOR H	ent tu	ALT 10Y	es 2∏No 3∏	Probably 4 Unknown
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u C	ding I h. After funer	ion	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Wo	ork?	28d. Describe h	ow injury occurred	
Division	or Attending Physician: after death. Director: Atter this certifica in by the funeral director, i	fical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home, farm, str		]Yes 2 □No	28f Location (S	treet and Number or	Rural Route Number
Ο̈́	ital or A	Certification:	4 Homicide determined	building, etc	(Specify)			City or Tow	n, State)	
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical	one)	iner: On the best of and manner sta	of my knowledge, deatle examination and/or in ted.	vestigation, in my	opinion, death occ	e, and due to the durred at the time, d	late and place, and d	ue to the cause(s)
•	To the To the comple	2	29b. Signature and fittle of certified	MI	)	29c. Licen	1266J		29d. Pate signed (Mo	nth, Day, Year)
-	5		30. Name and address of person who c	ompleted cause of d	eath (Item 23a) (Type,	Print)			-	
	9				PARK DR. GLEN	BURNIE, M	ID 21061			
	Sta Registr	-	31. Date filed (Month, Day, Year)		ur's Signature	and a				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For Amen #20b-c, perFH, 6863, 1/26/0/ TI Certificate of Decisions. Ensure All Copies Are I Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:39 AM Myllis Fuentes 2007 6 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** University of Maryland Medical Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🔀 F 67 245-54-9465 OH Director July 09 1939 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Directo Anne Arundel Odenton Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21113 490 N. Patuxent Road Lot #37 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Bookeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aldene Boggs Edwin Cales ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 490 N. Patuxent Road, Lot #37, Odenton, MD 21113 Raimundo Fuentes (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date LAN 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Holy Cross Cemetery 1/26/2007 Passedon, MD 22. Name and Address of Facility 21. Signature of Funeral Service L Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatitis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy . □ □ ve pirtn 2 □ Fetal dea: 4 □ Pregnant at time of death 9 □ Unknown in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P19729 16,2007 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hepp, University of Maryland Medical Center, 22 South Greene Street, Baltimore

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year)

2007

32. R

istrar's Signature

			1 - State Registrar	ate of Maryland / D			•	200"	01432
	Physici		Decedent's Name (First, Middle, Last)     George Monroe Finch	am				Day Year	3. Time of Death 7 5:55 P M
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street  Franklin Social  5. Social Sectrity Number 6. Sex  299-20-0881	Hospital Cen	to R		8. Date of Birth	9 Bi	
yland	No.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
ы Маг	Sa-f et	ector	MD Baltimore	Middl	e River				1 □ Yes 2 🗷 No
death with the Maryland	3a or 2 at be n	i Dir	10e. Street and Number 9 Control Ct.		10f. Zip Cod 2122		Į į	Citizen of What C	ountry?
5-0036		by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? ∐Yes 2 <b>D⊉N</b> ó Yes, Givé ear or Dates:	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Specuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
2) (C) 15-0 in 72 ho	n "netur Aedical	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	Decedent's Usual Oc (Give kind of work do life. DO NOT use ret	cupation ne during most of worki tired)	ing 16b	. Kind of Business	
6 60 d 2121	her the	Com	12	Ollege (1-4or 5+)	onstructio	n Foreman			
/land	Mental H irkad otl	То Ве	17. Father's Name (First, Middle, Last) Ray Fincham			18. Mother's Name	e (First, Middle, Maid Unknown	den Sumame)	
Mary Mary	27 le ma		19a. Informant's Name/Relationship (Type, Pl Dolores Collins/Daugh	rint) 19b. iter 4	Mailing Address (Stree 9 Taos Cir	eet and Number or Rura rcle Middle	al Route Number, Cit River, M	ty or Town, State, D 21220	Zip Code)
n ChC()が ( datinore, Maryland	nent of Hea ant: If Item ury or othe		20a. Method of Disposition  1 ≅Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	al from State cemeter)	Disposition (Name of commatory or other p	place)	Jan ZZ	. Location - City or	Town, State er, Maryland
Balt Permit.	Departi Import eny inj once.		21. Signature of Funeral Service Licensee	the MO(443	<sup>22</sup> Crematio 8717 Gre	n and Funera en Pastures	al Alternat Drive Bal	ives timore, M	Maryland 21286
Ex	he bu	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Is that caused the death. Do note on each line.  Due to (or as a consequence of the conse	f):	tying, such as cardiac c	or respiratory arrest,		Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760, ior Attending Physician: The law requires that the death certificate be executed	by the ettending pl tached for use as t	Physician/Mec	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □Pregnant at time of death □Unknown	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year
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on of	h. After thi funeral c	on: T	27. Manner of Death 28a 1 ☑ Natural 5 ☐ Pending	. Date of Injury 28b. Ti	me of 28c. In	jury at 2	ne 5 Residence 28d. Describe how in		cify)
)ivisio	fler death. Sirector: A n by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At home, farr building, etc. (Specify)		Yes 2 No	28f. Location (Street City or Town, Sta	and Number or Ru	ıral Route Number,
2- prof	within 24 hours after deatl To the Funeral Director; completely filled in by the	edical Ce	2 medical examinar: U	To the best of my knowledge, in the basis of examination and id manner stated.	death occurred at the or investigation, in my	time, date and place, a	and due to the cause and at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
Tothe	within To th compl	Me	29b. Signature and title of certifier	MD		nse number		Pate signed (Monti	n, Day, Year)
<del></del>			30. Name and address of person who complete	1 ~ i	115 0	Λ.	Baltimo		_
	Stat	e .	UI PITMAN HIME 31. Date filed (Month, Day, Year) JAN 2 3 2007	Registrar's Signature	hlin Squa	re prive	Daltimo	re Did.	21237
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07-00551 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Christopher Greenan State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day January 20, 2007 Medical Examiner 1320 hrs OHN haistopher 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death c. County of Death 6323 Ritchie Highway Glen Burnie Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. Jast birthday) **Funeral** Foreign Director 1 M 2 Usual Residence of Deceder Oc. City Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No death with the Maryland Director 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 2 No Yes Divorced If Yes, Give Year 1 Yes 2 No specify. Specify ( "natural" چ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 2,1215-0036

-ges I and 2 should be filed within 72 hou triment of Health and Mental Hygiene tant: If item 27 is marked other or other traumant Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) Be ۵ 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address City or Town, State, Zip Code) EDWARD D. GREENAN. crematory or other place Buriat 2 Cremation 3 Removal from State permit Pages
Department o
Important: Other Specify Donation 5 Daugherty Family Funeral Home And Cremation Center, P.A. tions that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one can Between Onset and /Medical Death Narcotic (heroin) and cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physician and the burial - trans Physician/Medical XUNPENDED AMENDED #23a,27,28a-f perMe. g864. requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Year past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23e Did tobacco use contribute to the cause of death? ş Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other<sub>4</sub> Inpatient 2 DOA ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene ۵ 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No 5 Pending 24 hours after death. To the Funeral Director: Fnd 1/20/2007 Fnd 1:12 pm unknown 2 \_\_\_ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6323 Rithie Hwy. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide X Could not be determined (Specify) Hotel 1 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 21, 2007 M Bord 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature Registra

07-00532 Richard Grady Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 19, 2007 Richard Francis Grady 1617 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death **Baltimore** University Hospital N/A 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8 Date of 8 irth (MM/DD/YYYY) 9. 8irthplace (State or 7. Age (In vrs. last birthday) **Funeral** Davs Hours Director 135-24-9460 Country) 1 X M 79 otober 20. New Jerse Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 28a-f show Yes 2 X No New Jersev Essex Montclair with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 42 North Fullerton Avenue 07042 USA 23a Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 8lack or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? nours after death 1 Never Married 2 X Married 1 X Yes Korea Yes 2 X No specify: Widowed Divorced If Yes, Give Year Specify. White à 16a Decedent's Usual Occupation (Give kind of work done 15 Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ u: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 12 should be filed within and Mental Hygiene. Medical Doctor **Me**dical . Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) William F. Grady Marian F. McParland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health and N : If item 27 is n Winifred Grady/Wife 42 North Fullerton Avenue Montclair New Jersev 07042 20b Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Jan. 24, 200 Upper Montclair, NJ. ment c Immaculate Conception Cem. Donation 5 Other Specify 22 Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21 Signature of Funeral Service Licenses Helton hustina 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Retween Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ysician UNPENDED AMENDED P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery signed by the attending phy be detached for use as the b 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? this certificate Yes 2 V No Yes 2 No Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other<sub>4</sub> examiner? DOA Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 1 Ves 2 No 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred 28b. Time of Injury Certification: a 24 hours after deam
he Funeral Director: A 1 V Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 20, 2007 30. Name and address of per in who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Mg Registrar's Signature JAN 2 3 State Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Helen Grimm January 17, 2007 10:47A Marv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 😾 F Director 216-38-2600 87 June 27, 1919 Virginia Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

'Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 USA 10 Stapleton Court #302 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ\ Specify: 3 Widowed 4 □ Divorced White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Morgan Hayes ပ Marv Louise Buchanan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 579 Polk Street, apt.4, Monterey, CA Thomas H. Grimm/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cockeysville, Maryland Ashland Church Cemetery 1/20/07 21 Signature of Funeral Service Months 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Metallatic probable **Physician** Cancer, monters /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probabiy 4 □ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Wospico 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST BATTHORE WD 21204 1 M 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 Registrar

07-00466 Louis Adrian Gonzalez

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		С	ertifica	ate of	Death			Re	eg. No	400	1 0190
Physici		1. Decedent's Name (First, Middle,Last)  2. Date of Death										3 Time of Death	
Medical Exam	iner		Adrian	Gona	zalez				,	Month January 1	7, <b>200</b> 7	Year 7	0343 hrs
		4a. Facility Name (if not institution	on, give street and nu	mber)		4	b. City, Town, o			_	4c. (	County of Death	
		521 Elizabeth Road					Glen Burni			_		ne Arundel	
Funeral		5. Social Security Number	6 Sex	7. Age (In yr	s. last birtl	nday)	If Under 1 Ye			B. Date of Bir	th(MM/D	D/YYYY) 9. Birtl Foreigi	hplace (State or
Director		158-76-3765	1XM 2F	3	34	Yrs.	Months Day	ys Hours	Min.	March	11.1		untry) NY
,		Usual Residence of Decedent											111
w any		10a State 10b. County		1	ity, Town		on						10d. Inside City Limits
Aaryland 28a-f show	ō	MD Anne	Arunde1	G1e	en Bu	rnie							1 Yes 2 No
Mary 28a- d at c	Director	10e. Street and Number					10f. Zip Code		· .	10	og. Citize	n of What Coun	try?
215-0036  be filed within 72 hours after death with the Maryland ntal Hyggiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		521 Elizabeth	Road				210	61			U.S	S.A.	
h witl ms 2 be n	Funeral	11. Marital Status	12. Was Dec		U.S		Decedent of Hi				- 14		can Indian, Black,
deati or ite	un <u>-</u>		1 X Yes	2 No	)	II Y E	s, specify Cuba	in, Mexican, F	Puerto Ric	an, etc.)		White, etc.	
after ral", iner	by		vorced If Yes, Give Year or Dates:			**		o specify:	Cuba		S	pecify: H1S	panic
hours af "natural"		15. Decedent's Education (Spe			16a. [	Decedent	s Usual Occupa st of working life	ation (Give kii	nd of work	done		nd of Business/In	,
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5-0036 led within 72 Hygiene. I other than 'the Medical	luc	12			Po.	lice	Office					Depart	ment
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	Ĕ	Mrs. Maritza Go	1 ( 3)	ther								or Town, State,	Zip Code)
두 글 풀 달 루		20a. Method of Disposition					Maserat:			ete			
프로프리		1 X Burial 2 Cremation	n 3 Removal fro			ry or othe		anietery,		23,	200. LQ	cation - City or T	rown, State
Lim Pag ment tant:		4 Donation 5 Other S		_   M	ary1	and V	Vets. Ce	em.	200	7	Cro	wnsvill	e, MD
Baltimore, permit. Pages 1 at Department of He Important: If ite		21 Sign are of Funeral Service	22 Sign Fre of Funeral Service Licensee  22 Name and Address of Facility Singleton Funer  1 Second Avenue SW Glen Burnie										о Р Л
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Physician /Medical	0	23a. Part I. Enter the disease, or failure. List only one cause	complications that ca on each line.	used the dea	ath Do not	enter the	e mode of dying	, such as car	diac or res	spiratory arre	st, shock	, or heart	Approximate Interval Between Onset and
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8760, tificate being physicas the buras the bu	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o	utcome of pre	egnancy							Date of delivery	-
certi	ciar	past 12 months?	I Live bi	ntn ant at time of	death 5		death 3	Ectopic p	pregnancy		M	lonth Da	ay Year
Records, P.O. Box 687 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as t	Physicia	1 Yes 2 No 9 Uni			5	Oth	er (Specify)				1		
O. It the		Part II. Other significant condit	ions contributing to	death but no	t resulting	in the un	derlying cause (	given in Part	I.	23e. Did tok	acco use	e contribute to th	ne cause of death?
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ion of Vital Records, tending Physician: The law requirient teath for: After this certificate has been sithe funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	မှ	1 Yes 2 No 27. Manner of Death	"	patient 2		patient			Nursing Ho			e 6 🗸 Other.	Scene
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ospita hours mera y fille	0	4 Homicide	(Opcony)	resid					[6]	<u>en Burn</u>	ie, M	ID	
Division  To the Hospital or Attention within 24 hours after death To the Funeral Director:	Medical	(Check only	hysician: To the best miner:On the basis o	of my knowle	edge, deat	h occurre	ed at the time, da	ate and place	e, and due	to the cause	(s) and n	nanner as stated	1
Tot with Tot	Med	29b Signature and title of certific	and manner sta	ated	- ariaror in				ired at the	ime, date a			
	=	and the order the	_/ // /				29c. Licens					te signed (Monti	h, Day, Year)
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		30. Name and address of person	1 1			4.5	O					<del></del>	
			Assistant Medica	-		1 Penn	Street, Balt	imore, M	D 21201				
St Regist	G.C.	31. Date filed (Month, Day, Year)	3 2007 32. Reg		10	1	ask)						
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Fune: Direct	_			nge (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir	9. Bin	rthplace (State or Foreign ountry)
land w t		-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ecation				10d. Inside City Limits
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h with the 23a or 2 st be no			10e. Street and Number 2173 ARRIBA REAL, UNIT 2	7-G	10f. Zip Code	3343	33	10g. Citizen of What G	ountry? USA
ING Z 1 Z 1 3-UU30  be filed within 72 hours after death with the Maryland ttal Hygiene.  ttal Hygiene.  do ther than "ratural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Ĺ	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes, Give	t Ever in U.S. 13. ? ] No	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	14. Race - Am Black, Whi	
Z15-UU36 thin 72 hours aff e. an "natural", or		Completed b	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retin	ipation e during most of work ed)	ing	16b. Kind of Business	/Industry
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aryland should be fill ind Mental H marked oth	i i	10 De	17. Father's Name (First, Middle, Last) HARRY	DRO	PKIN	18. Mother's Name		, Maiden Surname)	FRUCHT
Mar nd 2 sh llth and 27 Is m			19a. Informant's Name/Relationship (Type. Print) STEVEN GLASSER / SON			t and Number or Rui COURT - BE		er, City or Town, State, MD 21014	Zip Code)
			20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify)	e WELLWOOD			Date ./2007	PINELAWN,	
baltimor permit. Pages Department of Important: If its any injury or o	ouce.		21. Signature of Funeral Service Licensee	7 22	2. Name and Addr	ess of Facility SC	L LEVI	NSON & BROS	., INC.
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OF VI Physici r this cer	i i			tient 2 ER/Outpatier	" O DOX	her: 4 Nursing Ho	me 5□Resi	dence 6 Other (Spe	SON'S RESIDENCE
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	locib	ealcal	29a. Certifier (Check only one)  1	of examination and/or in	h occurred at the vestigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To th within	M	INIC	29b. Signature and title of certifier  Ruhend a Bay, 4	.0	_	se number 20604		29d. Date signed (Mon:	th, Day, Year)
i シ			30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	,	<b>,</b>	1 1	
	State		Richard A. Bers. 40; #450 31. Date filed (Month, Day, Year)  JAN 2 3 2007	trar's Signature	noi, Lutha.	AIR MA STOR	<u> </u>		
Reg	istra		JAN 2 3 2007	es de propos	Profession and Profes				

			For State Registrar	State of M	Marylar		artment o			ind Mer		ene	07	01439
	Dharini		1. Decedent's Name (First, Middle,	•							Date of Death Month	)	Vasa	3. Time of Death
	Physici /Medio		Antonio Galino	io							nuary	18	2007	10:28 Ам
1	Examir		4a. Facility Name (If not institution,	-	•		4b. City, Tov					1	y of Death	
			University of Ma	-			Balt					N/	/ A	
	Funeral		5. Social Security Number 112–32–7832	5. Sex 7 1XXM 2□F	Age (In yrs. 77	last birthday) Yrs.	If Under 1 Y Months Da		Under 2 Hours	Min. 8.	Date of Birth (Month, Day, 19 25,	Year)	9. Birthp	lace (State or Foreign try)
	Director		Usual Residence of Decedent		- / /	115.				Ma	ıy 25,	1929	Mexi	LCO
	iand ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						11	0d. Inside City Limits
	Many Hear	ţo	Maryland Anne	Arundel	Pas	sadena								1 ☐ Yes 2 X No
	r 28a	irec	10e. Street and Number				10f. Zip Co	de			10	g. Citizen of	What Coun	try?
	h with	ai D	735 Swan Cove La	ne			2112	22				United	1 Stat	es
	deat	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	.S. 13. \	Vas Decedent Yes, specify	of Hispa	anic Orig	in? (Specify	Yes or No-		ce - America	
9	within 72 hours after death with the Maryland ene. than "retural", or Itema 23a or 28a-f ahow than "retural", or Itema 23a or 28a-f ahow the Mudical Examir at must be notified at		1 ☐ Never Married 2 X Marrie	d 1 □Yes 2 b	ČίΝο		Yes 2XX		Specify:	, ruelto Alca	in, etc.)		ck, White,	
8	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	s:							Specif	<sup>y:</sup> whi	te
7	"net	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	ent's Usual O kind of work de	one durir	n n <i>g m</i> ost	of working	11	6b. Kind of B	lusiness/Ind	lustry
7	withir ene. then	ш	Elementary/Secondary (0-12)	College (1-40 5+	or 5+)	i	oo NOT use re Crician		າຄດດ໌	logiet	. [	mac	lical	
0 0	Hygi Hygi thar ant,		17. Father's Name (First, Middle, L.			ODSTE	LICIAN				rst, Middle, M.			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelin and Menth Hygiene. Importment of Heelin and Menth Hygiene. Integrated: If them 23 a or 28a-1 ahow any injury or other traumatic avant, the Mudical Examination must be notified at Once.	To Be	Antonio Galindo							cia Al		2.00,7.00,774,	,,,,	
ary	shound N		19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailin	g Address (St	reet and	Number	r or Rural Ro	ute Number,	City or Town	State, Zip	Code)
Σ	elth e		Teresita Galindo	/wife			Swan Co				adena,		21122	
altimore,	of He of He fitam	1	20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. P	Place of Dispo	sition (Name o	of place)		Date	20	Oc. Location	- City or To	wn, State
Ĕ	Pag ment ent: I ury o		4 □ Donation 5 □ Other (Spe		.0				y ˈJa	ın. 22,	2007	Baltin	nore.	Maryland
ä	permit. Departi Import		21. Signature of Funeral Service Li	censee III			Name and Ad							
<u> </u>	205 g		yohn O. Mu	Whell			0วบบ	) tor	CK_KC	a. //E	sartimo	re, m	212	212
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus nly one cause on each	ed the deat line.	n. Do not enti	er the mode of	dying, si	uch as c	ardiac o res	spiratory arres	st,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	_ a. Traumat	ic Br	ain In	jury		1	11/1	1 ,			Onset and Death
	/Medical Examiner		resulting in death)		as a conseq				11	77/		.=0		
	FALL	_	Sequentially list conditions,	b. Due to (or a	as a conseq	ience of):			111	7 /w	E	AMINE		
Т	rted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or Injury	200 10 (0) 2	10 4 60//304	dones or,			41	POROVED	BA WED.			
o o	be executed sicien and burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or a	as a consequ	uence of):		-	UEIC .	F1 W.	BY MEDICAL EX			
8760	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	icai		d.				CEL						
89	ng ph		IF FEMALE:											
Box	eath certific attending p	an/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	ne of pregna 2 ☐ Fete	ncy I death 3	Ectopic pregna	ancv				1	te of deliver	•
0	the all	Physicia	1 Yes 2 No	4□Pregnant 9□Unknown		eath 5	Other (specify	v)				Mo	onth (	Day Year
<u>.</u>	res that the de signed by the a be detached f	Ph	Part II. Other significant condition	s contribution to death	but not race	ulting in the un	dashiina anusa	auon in	Doet		22a Did taba		official an ab-	e cause of death?
Vital Records,	signe d be	a p	action original contains	o contributing to coatt	Dut not 1931	atting in the ut	denying cause	a divais in	irani.			2 🕅 No		bly 4 Unknown
Š	w require	ete								_				
Re	The lav	Completed								-	24a. Was an autopsy performe		Were autop prior to com death?	sy findings available apletion of cause of
		ပိ	25. Was case referred to medical	_	Contraction	_	*)}		~		1∐ Yes 2∑	No	1 ☐ Yes 2	2 <b>)X</b> No
	ysician: is certifice director, I	ToB	examiner? 1 X Yes 2 No	Hospital:	tient 2 🗆	ER/Outpatient	317 DOA	04			eck only one. 5 □ Residen		(0 (	
<u>0</u>	ter thi		27. Manner of Death	28a. Date of In		28b. Time of		njury at Work?			Describe how			<u> </u>
<u>o</u>		atio	1 □Natural 5 □ Pending 2 ☒ Accident investiga	Jan. 17		Injury unknowi		work? 1 ∐ Yes	2 <b>X</b> N	0	fall			
Division of	r Att	Certification;	3 Suicide 6 Could no 4 Homicide determin	be One Diese of I				ice		28f. L	ocation (Stre	et and Numb	er or Rural	Route Number,
2	ital or irs afte ral Dir			У	ard					735	Swan C	ove La		sadena,MD
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical	CONSCITUTE ZU MEDICALES	Physician: To the bes	of examinat	wledge, death ion and/or inv	occurred at the	e time, d	ate and	place, and o	due to the cau	se(s) and ma	nner as sta	ited.
	To the within 2 To the complet	Med	29b. Signature and title of centrier	and manner s	stated.			ense nu				I. Date signe		
)	F 3 F 8	11				10				011- 0		1 ~ 1	- (moran, D	wy, 10ai/
	6	1	30. Name and address of person wh	o completed cause of	death (Item	23a) (Type F				01129		1181	200/	
_	9		CARIOS J. ROD	RIGUEZ	MI	22	Print) S. GREE	NE S	TREC	I. B	BATTIM	ore, M	10 2	1201
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signal	ture Asset	2 0							
	Registra	ar -	101 9 3 20	17 Page oc	, 15	GO SA	Size.							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ellen Martin Howell /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 2117 Edmondson Avenue Catonsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 218-52-8953 Director 57 Usual Residence of Decedent 10a. State 10c. City, Town or Location show Medical Examiner must be notified at Director Worcester Maryland 28a-f Ocean City 10e. Street and Number 10f. Zip Code 23a or 13601 Wight Street #8 21342 72 hours after death Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 "natural", or þ 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed

10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry

Medical

20c. Location - City or Town, State

Year

2007

Baltimore

4c. County of Death

3:30 P.M

Birthplace (State or Foreign Country)

Washington D.C

10d. Inside City Limits

1 X Yes 2 ☐ No

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname) Anna Sullivan

2. Date of Death

January 17,

8. Date of Birth (Month, Day, Year)

June 18,1949

Month

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13601 Wight Street #8; Ocean City, MD

20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 1/19/2007 Catonsville, Maryland

22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsvill

23a. Part1. Ent. th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. OVARIAN

Approximate Interval Between Onset and Death

disease or condition resulting in death)

Due to (or as a consequence of)

year

Sequentially list conditions, if any leading to unit cause. Enter Underlying Cause (Disease or injury that initiated events soulding in death).

IF FEMALE:

Due to (or as a consequence of)

Due to (or as a consequence of):

resulting in death) Last

23b. Was decedent pregnant

1 ☐ Yes 2 ☑ No

9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1. Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

William Howell

Mary Gavin

20a. Method of Disposition

21. Signature of Funeral S

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

9□Unknown

4☐Pregnant at time of death

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) 4☐ Nursing Home 5☐ Residence 6 MOther (Specify) HOSPICE

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

Other:

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifie

5 Pending investigation

6 ☐ Could not be

00043934

PLACE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

227 MIO

31. Date filed (Month, Day, 32 Registrar's Signature IAN 1 9

State Registrar

20

DHMH 17 Rev 1/2001

2 should be filed within 7, and Mental Hygiene.

s 1 and 2 should be fiif Health and Mental H tem 27 Is marked oth

Pages 1

**Department** 

**Physician** 

/Medical

Examiner

the burial-transi and

signed by the attending physician d be detached for use as the buria

been :

has page 2

funeral director,

filled in by the within 24 hours after death To the Funeral Director:

this

After

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

the

traumatic

Item 27

Important: If It any injury or o

B

2

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE MO 21202

1/18/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8864 2-1 107 Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Elwood Hicks 2. Date of Death Month Jr. Physician Year 4:28 AM ELLWOOD January 2007 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NA UNIVERSITY OF MARYLAND MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Aug. 23,1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11XM 2□ F 214-46-0719 59 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at MD Anne Arundel Glen Burnie Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Point Pleasant Road 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036

Department of Health a Important: If Item 27 is any injury or other trains **Physician** /Medical

**Examiner** 

and	-transi	
To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	
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To the Funeral Director:	ıblei	
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5

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 3 2007

32. egistrar's Signature

**ORIGINAL** 

Division or Vital Records, P.O. Box 68760

ò	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 № No Specify:	•	Specify:	White
eted	15. Decedent's Educa (Specify only highest grade of	ation completed)	16a. Decedent's U	sual Occupation work done during most of wo	orkina 1	Kind of Busines	s/Industry
Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	\life. DO NOT	work done during most of wo use retired)		Tees a 1 a d as as	
ပ္	17. Father's Name (First, Middle, Last)		Tares C		me (First, Middle, Maid	Trucking	
o B	Elwood William Hid	cks. Sr.		Julie B		on Gamano,	
Ĕ	19a. Informant's Name/Relationship (Type		19h Mailing Addre	ess (Street and Number or R			7-0-4-1
		•					
- 1	Mrs. Susan Hicks/Wi		ace of Disposition (A	int Pleasant	Road Glen I	Location - City o	MD 21060
	1X Burial 2 □ Cremation 3 □ Rea	emoval from State	ace of Disposition (Nemetery, crematory of		1. 1/,	Location - City o	Town, State
	4 □ Donation 5 □ Other (Specify)	A	yland Vet			rownsvil	
	21. Signeture of Funeral Service Vicensel	IXUL MOISI	£4 1 Se	cond Avenue S		Funeral	Home, P.A. 21061
	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one immediate Cause (Final	e cause on each line.			ac or respiratory arrest,		Approximate Interval Between Onset and Death
	disease or condition resulting in death)	MYOCARDI.		ARC TION			
	Sequentially list conditions b.	Due to (or as a consequ	ence of):				7 days
sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):				
all	Cause (Disease or injury that initiated events resulting in death) Last						
ŭ	resulting in death) Last	Due to (or as a consequ	ence of):				
Sa	d.						
Med	IF FEMALE:						
and	23b. Was decedent pregnant 23c	<li>c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal</li>		pregnancy		23d. Date of de	•
SIC	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of de 9☐Unknown				Month	Day Year
5	9 Unknown						
2	Part II. Other significant conditions contr	abuting to death but not resul	Iting in the underlying	g cause given in Part i.			to the cause of death?
pleted					1 Tes	2 No 3 P	robably 4 □Unknown
ble					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
E					performed? 1□ Yes 2 <b>⊠</b> 1	death?	
ge C	25. Was case referred to medical			26. Place of De	ath (Check only one)	10 1016	5 2 140
0	examiner?	ospital: 1∭inpatient 2 ☐ E	R/Outpatient 3 ☐ I		Home 5 Residence	6 ∏Other (Spe	acify)
- 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	Joney
TIII Cation:	1.XX Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Todi)	M	1 ☐ Yes 2 ☐ No			
5	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, street, fact	ory, office	28f. Location (Street	and Number or F	Pural Route Number,
Ş		ballating, etc. (Opeciny)	,		City or Town, Sta	110)	
Medical	29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine	cian: To the best of my know er: On the basis of examinati and manner stated.	vledge, death occurre ion and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner a	s stated. e to the cause(s)
Mec	29b. Signature and title of certifier	and manner stated.		9c. License number			
-	100-00	44.5				ate signed (Mon	
		MD		P21187	10	inuary 1	2 2007
	30. Name and address of person who com					- 1	
_ [	ROBIN ENCK, MD	22 S. Gree	ne St. C	saltimore:	MD 2121	01	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Margaret Elizabeth 2007 Hoch ANUAR /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE LOASHINGTON MEDICAL CENTE ANNE BURNE ARUNDE 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☑ F Months Days Hours Min 174-20-5181 Director 93 3/4/1913 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits items 23a or 28a-f shov iner must be notified at MD Director Anne Arundel Millersville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8263 Mimico North "natural", or items 23a edical Examiner πust β 21108 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ white 3 ☑ Widowed 4 ☐ Divorced Specify Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing 5+ Nurse Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 2 Alonzo Steele Elizabeth Slicer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stanley Hoch Jr./SON 1115 Wandering Oaks Dr., Norman Beach FLA 32174 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 4 ☐ Donation /5 ☐ Other (Specify) 1/22/2007 Middle River, MD 21. Signal re of Full al Service Licens 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TATLUPE TCHTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BSTIZUCTIVE FOLMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the The law requires that the death certificate use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☑ No detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. signt be c Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 4 Nursing Home 5 Residence 6 □Other (Specify) funeral 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury ours after death, neral Director: A filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29b. Signature and title of certifie 29c. License number MO 1001 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month,

3

star's Signature

Len Barnie

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 19, 2007 Albert Francis Hall 2:07 A. M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph's Hospital Baltimore Towson If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
July 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 217-34-6780 68 Director 1938 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore Funeral Director XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be I 2803 Miles Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Roofer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John H. Hall Rhoda ₩ol fe ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bush Sister 2816 Miles Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of uneral Service Licensee 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infant 40-15 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autonsv perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attendential 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ompletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1006 1199 Jan. 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 209, Touson MD 21204 6565 North Charles ST. Black. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 144 State of Maryland / Department of Health and Mental Hygiene / 1) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 Month aVYISON **Physician** 16:30 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) Examiner HOSPITA Baltimore DSEGOLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 213-38-9205 66 Yrs. 12-23-1940 NEW JERSEY Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County wode ! item 27 ie marked other then "netural", or iteme 23a or 28a-f ebov other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes XXNo MD BALTIMORE Director MIDDLE RIVER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10023 ICABOD LANE 21220 U.S.A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 20 Married 1 ☐ Yes 2X No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SAFTEY DIRECTOR IRS 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **JAMES** SWALLWELL LAURA (ABEL) Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) EDWARD HARRISON/HUSBAND 10023 ICABOD LANE MIDDLE RIVER, MD 21220 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 <u>=</u> 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Depertment of important: if eny injury or once. 1-20-2007 CATONSVILLE, 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Lntracrania **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ot) Examine The law requires that the death certificate be executed attending physicien end for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 21 No 3 Probably 4 | Unknown 1 TYes been si 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No paga 2 after death.

Director: After this certificate if in by the funeral director, pag 1□ Yes Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 V Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient ဥ 2 ER/Outpatien! 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) T. M. sollie. K Frank 0 D36663 who completed cause of death (Item 23a) (Type, Print) Name and address of person Franklin Square Drive 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOSEPHINE $\frac{2}{2}$ 0 HOLLE JANUARY 2007 /Medical 7:00A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE ROSSVILLE ROSEDALE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 8. Date of Birth (Month, Day, Year) 8. 18. 1913 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 1 F Months Days 214 03 2563 Director 93 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified Director MD n/a BALTIMORE 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a 3212 ELLIOTT STREET 21224 IISA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 ☑ No Specify. ð Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Il Hygiene. College (1-4or 5+) the HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any Injury or other traumatic event Be 18. Mother's Name (First, Middle, Maiden Surname) STANISLAUS KALINOWSKI MARYANNA POMYKALA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARION SCHNEIDER/NIECE 1527 NEIGHBORS AVE BALTIMORE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4⊠Donation 5 ☐ Other (Specify) STANISLAUS 1/23/07 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying causs (Lissass or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-trag Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent prégnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Day Year 5 ☐ Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has 24a. Was an autopsy performe certificate 1∐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural (Month, Day death. 2 Accident 1 🗌 Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death e Funeral Director; Medi

Baltimore, Maryland 21215-0036

To the within 2

State Registrar

DHMH 17 Rev 1/2001

Check only

29b, Signature and title of certifier

30. Name and address of person who cor

one)

HETE BACK 201 31. Date filed (Month, Day, 32. Ragistrar's Signature Year)

pted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 19, Charles Hull2007 1:10 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Stella Maris Baltimore Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March 27,1934 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 2 F 215-30-8163 72 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10602 Partridge Lane B2 21030 USA "natural", or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Irvina Hull Gertrude Corcoran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte G. Hull / Daughter 744 Overbrook Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. John's Cemetery 1/23/07 Ellicott City, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1050 York Road Ruck Towson Funeral Home, Inc.Towson,Md.21204 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GALLBLADDER CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, JAN 2 3 State Registrar

19, 2007

JANUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dorothy B. Haar January 19, 2007 5:30 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F 90 Yrs. Director 573-16-4602 Usual Residence of Decedent Jan. 1, 1917 Kansas the Maryland r 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 為 No Montgomery Bethesda Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. be r "natural", or items 23a 8809 Burdette Road Funeral 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, GiveX Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🗓 No White Specify: 3 XWidowed 4 □ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Amos Bromley Mary Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan H. Gordon/Daughter 8809 Burdette Road, Bethesda, MD other 1 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. January 25. 1 Strain 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pohick Church Cemetery 2007 Lorton, Virginia 21. Signature of Funeral Service Licensee Robert A. Functivey Funeral Home, Bethesda-Chewy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Millian Mostly MO1173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician disease or condition resulting in death) d445 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 9□Unknown Day Year signed by the a 5 ☐ Other (specify) Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page certificate Vital med? 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 ō After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred lospital or Attending hours after death. Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 19, 2007 056652 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1201 Seven Locks Rd #200, Rockville, MD 20854 Poffenoth Matthew MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JAN 2 3 2007

Held !

32. Registrar's Signature

			1 - For State Registrar	State of Ma			f Health and	Mental Hygie	ne 2007	01448
п	Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day , Year	3. Time of Death
	/Medi	cal		DROW	HIEBLE				9/200	7 7:20 PM
	Exami	ner	4a. Facility Name (If not institution, give s.				n, or Location of Deat	h	4c. County of Deal	th
			VA BALTMORE  5. Social Security Number 6. Sex	1-11-0	(In yrs. last birthday)	If Under 1 Ye	MORE oar   If Under 24 Hrs		N/A	
	Funeral Director			M 2 F	P. T Yrs.	Months Da		(Month, Day, Ye		hplace (State or Foreign buntry)
	D .		Usual Residence of Decedent					4/22/1	919 N	MARYLAND
	show	-	10a. State 10b. County	1	I Oc. City, Town or Lo	cation				10d. Inside City Limits
	8e-f	Director	MD BALTIMOR	E	PARKVILL	,E				1 ☐ Yes 2 🟋 No
	with th	Dire	10e. Street and Number			10f. Zip Cod	е	10g.	Citizen of What Co	untry?
	s 23	erai	8705 EMGE ROAD				1234		USA	
10	fter dea	Funerai	11. Marital Status 1: 1 Never Married 2 Married	<ol> <li>Was Decedent Ev Amed Forces?</li> <li>1 ∑Yes 2 □ No</li> </ol>	er in U.S. 13. \	Vas Decedent of Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.
936	hours after death with the Maryla tural', or Itams 23a or 28e-f show Extrail of Installation notified at	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates: WV	<i>)</i> TT	☐Yes 2 <mark>数</mark> 1	No Specify:		Specify: WHI	TE
2-0	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28e-f show the Marital Extra the notified at	Completed	15. Decedent's Educa	ation	16a. Deced	ent's Usual Oc	cupation	16b.	Kind of Business/	
2	d within giene. r than "	npie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(GIVe	kind of work do OO NOT use ret	ne du <i>rina most of woi</i>	rking		,
2	TI TO =		12TH GRADE		REPA	IRMAN		F	RADIO & T	V
anc	be ital	Be	17. Father's Name (First, Middle, Last)  JOHN J. HIEBLER				18. Mother's Nan	ne (First, Middle, Maid	en Sumame)	
Maryland 21215-0036	should be and Mental I	2	19a. Informant's Name/Relationship (Type	a Dried	101 111			MEYERS		
Ma	nd 2 sho alth and 27 Is m		BARBARA DELL/DAUGHT					ral Route Number, City		
ē,	Hei Hei tam otha		20a. Method of Disposition		20h Place of Disnos	ition /Name of		BALTIMORE,	MD 2122 Location - City or 1	
Baltimore,	permit. Pages Department of I Importent: If itt any injury or or once.		14 Burial 2 ☐ Cremation 3 ☐ Rei 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	GARRISON	atory or other p FOREST	VA 1/26			
alti.	permit. I Departm Importer any inju		21. Signature Funeral Service Licensee	1/	CEMETERY		11/20/	JOHNSON F	NGS MILL	OME DA
ä	Depa Impo any ii	1	Heather N	Hach	85.	21 LOCH	RAVEN BLY	D. TOWSON		286
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the	e death. Do not ente	r the mode of d	ying, such as cardiac			Approximate
	Physician		Immediate Cause (Final disease or condition	SEVERE	AORTIC	STEA	M-15			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):	SILI	2) 20,			2 3003
	LAGIIIIICI	<b></b>	Sequentially list conditions, b.							
$\mathcal{T}$	led nsit	nine	day, leading to minoriate cause. Enter Underlying Cause (Disease or injury	Dué to (or as a c	onsequence of).					
v _^	al-trai	Examiner	that initiated events c. resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	icate be executed physician and s the burial-transit	dicai [	d							
89	tificat 19 phy as th	ledi								
Вох	leath certific attending p	an/N	Loss was account program	. If yes, outcome of p 1□Live birth 2 □					23d. Date of deliv	erv
0	ed for	Sicis	in the past 12 months?	4 Pregnant at tim		Ectopic pregnan Other (specify)	су		Month	Day Year
<u>Ч</u>	that the de led by the a detached f	Physician/Me	9 Unknown							
Ś	5 50	þ	Part II. Other significant conditions contri PULMONARY	EMBOUS		derlying cause g	iven in Part I.			he cause of death?
Ö	w require been si should b	etec		- MECH 3	7			1 Tes 2	2 XNo 3 □ Prot	oably 4 Dunknown
Records,	ne law has l ge 2 s	Completed	ACUTE RENAL	FAILUI	RE			24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of
			05 14/2					performed? 1 ☐ Yes 2 N	death? 1 ☐ Yes	2 No
<b>=</b>	Physician: rthis certifica	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hos	pital:	a[[[50/0]	-7 0	than	h (Check only one)		
0	g Phy erthi	$\vdash$	27. Manner of Death	1 Anpatient 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA	4   Nursing Ho	me 5 Residence 28d. Describe how inju		(y)
0	death. ctor: After y the funera	atio	1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	28c. Inju We M 1 [	ork? ]Yes 2∐No		., 00001100	
Division of	or Attand after death Diractor: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide	28e. Place of Injury - building, etc. (S	At home, farm, stree	t, factory, office		28f. Location (Street a	nd Number or Rura	Il Route Number,
	spital o	Cer		Dallaling, etc. (c	рвспу)			City or Town, State	9)	
	I o the nospital or Attending Physician: within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one)	en: To the best of m	y knowledge, death o	occurred at the t	time, date and place,	and due to the cause(s	) and manner as s	tated.
	o the Hos within 24 h To the Fur completely			and manner stated						
1	- × - 8		29b. Signature and title of certifier	<b>D</b> 8	1		ise number	29d. Da	te signed (Month,	
	140		20 1/2	BOUGHA			583		19/200	T
	10		30. Name and address of person who comp				T. RA.	TIMORE ME		
, inc	Stat	e	31. Date filed (Month, Day, Year)	Registrar's	Signature	Teve !	>1. DHr	TIMORE MI	2120	1
	Registra		JAN 2 3 2007	and were	H Anon					

			Please  1 - For State Registrar	State of M		d / Depa	artmer	nt of H	Ensure A ealth and M Death	lental Hy		0 0 7	and a	49
	Physici /Medio		Decedent's Name (First, Middle, La     Ma	ae Ethel H	enkel					2. Date of De.	Day	Year ZPZ	3. Time of 12:75	
	Examir		4a. Facility Name (If not institution, give Bath me Washing	1 00 1		ntee	4b. City.	Town, or	Burne		4c. C	ounty of Deat	Anand	lal.
	Funeral Director		5. Social Security Humber 0. C			ast birthday) Yrs.	If Unde Months	r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 12	h v. Year)	9. Birti Co	nplace (State of untry) yland	r Foreign
_			Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Cit	
	r 28a-f si	Funeral Director	Maryland N/A  10e. Street and Number		Ва	altimo		p Code			10g. Citize	n of Whal Co	1 <b>K</b> Yes	2 No
1	eath with	eral D	4014 Fairhaven	Avenue	Ever in U.	S. 13. V	Vas Dece	212		ecify Yes or No		.S.A.	rican Indian,	
(T) (T) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Them "naturel", or items 23s or 28s-f show ent, the Medical Examitment and the notified at	by	1 Never Married 2 Married 3 A Widowed 4 Divorced	Armed Forces?  1 Yes 2 X  If Yes, Give  Year or Dates:	?		fYes, spe t⊡Yes		spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, White	etc.	
ンメル	nin 72 h in "natu Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)	16a. Deced (Give life. L	tent's Usu kind of wo DO NOT u	ial Occupa ork done o ise retired	ation Juring most of work )	ing	16b. Kind	of Business/	ndustry	
E E	filed with Hygiene. other ther		7th 17. Father's Name (First, Middle, Last			Stor	e Ow	ner	18. Mother's Nam	e (First, Middle,		ocery		
T Aland	should be and Mental marked o	To Be		ey Frankli	n					ude Wid				
Mary	nd 2 lith a 27 is		19a. Informant's Name/Relationship ( Verna Leonard /				-		and Number or Rur 1 Avenue				ip Code) ryland	21146
MAE.	L H E		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation _ 5  Other (Special			lace of Dispo emetery, cren ar Hil				2007		more.	Town, State	d
MAE Baltimore,	permit. Page Depertment of Important: if eny injury or		21. Signalive of Funeral Service Lice		oeu				e Highwa					
			23a Parti. Enter the disease, or conshock, or heart failure. List only	inglications that cause	d the death							, ridi y	Approximate Interval Betv	veen
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	anco	ed			ontro	· · · · · · · · · · · · · · · · · · ·			Onset and D	eatn
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V	i be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):								
38760,	icate be physicie s the bur	- CG	•	d										
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completaly filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic p Other (s)	regnancy pecify)			23	d. Date of deli Month	•	'ear
	quires that n signed b uld be deta	ρ	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the ur	nderlying	cause give	en in Part I.	23e. Did to			the cause of de obably 4 □U	eath? Inknown
Division of Vital Records,	The law re- ate has bee page 2 sho	Completed								24a. Was autop perfo 1 \( \text{Yes}	sy	24b. Were au prior to death?	topsy findings a ompletion of ca	available ause of
Vita	sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:		FB/0-44		Othe	26. Place of Deat			704/6	4.1	
on of	nding Phys th. : After this e funeral di	ation: To	1 Yes 2 No  27. Magner of Death 1 (Natural 5 Pending investigation investigation)	28a. Bate of Inju	ury	ER/Outpatien 28b. Time of Injury		28c. Injury Work	4   Nursing no	28d. Describe h			eny)	
Divis	affor Atter affor dea Director d in by the	Certification:	3 Suicide 6 Could not be determined		jury - At ho tc. (Specify	ome, farm, stro	eet, factor	ry, office		28f. Location (S City or Tox		Number or Ru	ral Route Numb	ber,
	Hospits     24 hours     Funeral     Interest of the fille	edicai C		hysician: To the best miner: On the basis of and manner st	of examinat									
	To th withir To th comp	Me	29b. Signature and title of certifier	£ 4 A			29	C. License	number		29d. Date :	signed (Month	, Day, Year)	n =7
	3		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	75	9//		<i>-</i> 4744	my	17 al	ルナ・
	Sta	ato.	31. Date filed (Month, Day, Year)	n. 30	rar's Signal	ter !	ملاك ل	ه,	Vuen &	unne	ma	٠- 51	06).	
	Registi		JAN 2 3 2	007	10 1	K A	and .	,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 22, 2007 **Physician** HELEN 4:10A HULSH0FF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 621 Murdock Road Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) September 30,1916Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 □ M Yrs. 90 216**-**03-5473 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 USA 621 Murdock Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes XX No White Specify. ò 3 ☐ Widowed XX Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) 0wner Tavern 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Polianski Anastasia Radauskas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DTR 1311 Wildwood Drive Fallston, Maryland 21047 Joan M Fitzpatrick 20a. Method of Disposition

No Burial 2 □ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐Removal from State 1/24/07 Holy Cross Cemetery Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral Service Licensee Jennis 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Immediate Cause (Final disease or condition resulting in death) year **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death 3 □ Ectopic pregnancy Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available phor to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1☐ Yes 2☐No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Registrar's Signature 31. Date filed (Month, Day, Year) 3 200

6 BMC

30. Name and address of person who completed cause of Seath (Item 23a) (Type, Print)

M. A. R. Le G. BMC 6701 N. Charles St. Balto. Md

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

JANUARY 22, 2007

07-00561 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anton Jones, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Da 2200 hrs Medical Examiner ANTON JONES D. JR. January 20, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYY) 9. Birthplace (State or Funeral oreign Months Davs Hours Min Director 220 13 8898 19 Yrs Country)MD 1 × M 2 28,1987 MAYUsual Residence of Decedent ıny 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No 28a-f show notified at once, BALTIMORE MD. N/A death with the Maryland rector 10e. Street and Number 10f. Zip Code log. Citizen of What Country 21206 USA 5849 ARIZONA AVENUE or items 23a or 듑 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 XNever Married 2 Married 2X No Yes after ( Yes X2 No specify If Yes, Give Year Widowed Divorced Specify: BLACK "natural" 2 Pages 1 and 2 should be filed within 72 hours a nent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturs 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Baltimore, MD 21215-0036 12TH MAI SORTER PSI GROUP 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be ANTON D. JONES, SR. SHARRON JACKSON 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other traumatic SHARRON JACKSON mother 5849 ARIZONA AVE. BALTO, MD. 21206 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 Cremation 3 crematory or other place) rtant: PARKWOOD JAN. 27, 2007 BALTIMORE, MD. CEMTERY Donation 5 Other Specify: nature of Funeral Service Licenses 22 Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME permit Depar Impor o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications that caused the dev Approximate Interval **Physician** failure. List only one cause on each line 8etween Onset and /Medical a Multiple Gunshot Wounds Death Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Physician/Medical UNPENDED **AMENDED** attending physician Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) æ Other<sub>4</sub> Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 2 1 V Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jan 20, 2007 Subject shot 2130 hrs Natura 5 Pending Yes 2 V No the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 5464 Cedonia Road, Baltimore, MD determined (Specify) Sidewalk 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical one) 2 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director:

State

31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Carol Allan, MD

and manner stated

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 21, 2007

**ORIGINAL** 

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TONES Month Day BETTY 20:13 M IANUARY 20, 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 4, 1925 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 213-20-5776 1 □ M 2 💢 F Days Hours 82 Yrs. Director Kansas Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits be notified at Baltimore City Director Maryland Baltimore 1X□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21234 3601 Northway Drive USA 23a must Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1<sup>College (1-4or 5+)</sup> Elementary/Secondary (0-12) Private Secretary Franklin Square Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Cleveland Lindsey Effie May Cox 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Sheppard/Sister 3534 Northway Drive Baltimore Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Feb. 9, 2007 Arlington National Cem. 4 ☐ Donation 5 ☐ Other (Specify) Arlington Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 huster 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY HYPOXIC FAILURE WEEK /Medical Due to (or as a consequence of): **Examiner** RESPIRATORY DISTRESS SYNDROMS-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACUTE Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 🗌 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No page 2 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Division or Vital Records, P.O. Box 68760, certificate l funeral director this To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After the Completely filled in by the funeral After t

5 ☐ Pending investigation 6 ☐ Could not be determined

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b Time of (Month, Day

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. one) 29b. Signature and title of certifier

2 No

1 Tes

27. Mangler of Death

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

1 Natural

29c. License number

RES-000

29d. Date signed (Month, Day, Year) JANUARY 20, 2007

Culnum Sund Malsh, MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADNAN MALIK, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287 31. Date filed (Month, Day, Year)

Registrar

Certification: To

Medical



To the Hospital c within 24 hours af To the Funeral D

6

		-	State Registrar		-	Ce	rtificat	e of i	Death	1		Reg. No	<b>o</b> .			
01			1. Decedent's Name (First, Middle,	Last)							2. Date of E	eath \	11	Year	3. Time o	of Death
Phys /Me	sicia edica		KATHARINE .	TEFFERS	ON.						TANUAR				740	M
	mine		4a. Facility Name (If not institution,	-	ber)				Location	of Death			c. County o			
		7.	Northwest Hos	-			Rand			0411			Balti			
Funer Direct			214-14-8343	3. Sex 7. 1 □ M 2 🛣 F	. Age (In yrs.	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, I May 17				lace (State try) <b>yland</b>	
land ow		+	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							11	0d. Inside C	City Limits
the Mary 28a-f eh		O	Maryland Balti	more	Ha	lethor	0e 10f. Zip	Code				100 0	itizen of W	hat Coup		2 <b>∑</b> No
Ore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after deeth with the Maryland gos 1 and Amental Hygiene. If them 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be notified at		ra Dir	4841 Carmella I					2122					Unit	ed S	tates	;
fter de r ttem		by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Force 1 Tyes 2	es? ⊠No	1			ispanic Or In, Mexica	rigin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	10-	14. Race Black	, White,	etc.	
O36 ours a		۵	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 🗌 Yes	2 <b>X</b> No	Specify:	:			Specify:	Wh:	ite	
22 hg		eted	15. Decedent' (Specify only highest			16a. Dece	kind of wo	rk done d	during mos	st of workir	ng	16b. H	Kind of Bus	iness/Inc	lustry	
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 le marked other than "natural", or traumatic event, the Madical Exam		Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)		DO NOT u		)			D	_+_ <u>-</u> 1	Foo		
Hygie A.		S -	11 17. Father's Name (First, Middle, L	ast)		He	ostes	S	18. Moth	er's Name	(First, Middl		etail n Sumame		<u>a</u>	
landid be left be ked o		o Re	John Joseph Hoo	·							ret El					
aryla should and Men	- I		19a. Informant's Name/Relationsh			19b. Mailir	ng Address	(Street			/ Route Num				Code) 21	228
and 2 and 2 belth a n 27 le			Katharine F. Y	oung / Dai	ughter	193	7 Old	Fre	deric	k Ro	ad, Ca	tons	ville	, Ma	rylan	d
or He se transfer of the se tran		1	20a. Method of Disposition 1 ØBurial 2 ☐ Cremation	I □ Bernoval from St		Place of Dispo cemetery, crei	sition (Nar	ne of ther plac	e)	D	ate	20c. L	ocation - C	ity or To	wn, State	
Peg ment ment:	1		Donation 5 ☐ Other (Sp	ecify)		orraine				1/25	/07	Bal	timor	e, M	aryla	nd
Baltimore, permit. Peges 1 ar Depertment of Hee Importent: If Item eny Injury or othe	DCS		21 Signalure of Funeral Service L	censee			. Name an			m	bbard					
	-	-	23a. Part1. Enter the disease, or o	Considerations that can	Used the deal						e, Bal		re, M			
			shock, or heart failure. List o	nly one cause on eac	th line.										Approximation interval Bet Onset and	tween Death
Physicia /Medic			disease or condition resulting in death)	a. END	as a consec	E CH	RON	0	BSTRI	UCTIV	ie lui	16 1	DISE	456		
Examin				_		HEA	Fall	NAE								
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	quence of):	VE HEART FAILURE.											
ocuted nd transi		Examiner	Cause (Disease or injury that initiated events		an off											
50, se exe		Ĭ	resulting in death) Last	Due to (or	as a conseq	quence of):										
68 760, ificate be ex physicien as the burial	1	Medical	ž.	d										-		
BOX  Bath cert attending for use		Physician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown		h 2∐Feta ntattime of d	al death 3	Ectopic pr Other (sp						23d. Date Mont			Year
Cords, P.O.  requires that the de been signed by the s should be detached		2	Part II. Other significant condition	s contributing to deat	th but not res	sulting in the u	nderlying c	ause give	n in Part I		23e. Did	tobacco	use contrib	ute to the	e cause of c	death?
Hecords, he law requires t a has been signe ge 2 should be c		5									1 🗆	Yes 2	□No 3	☐ Proba	ably 4 X	Unknown
awre as bee	100	completed									24a. Wa		24b. W	ere autop	sy findings	available
The lay		Ę									auto perf	ormed? 2 No	de	ath?	ipletion of c 2∭2 No	ause or
VITAL I piclen: Th certificete rector, pag		D	25. Was case referred to medical examiner?						26. Place	of Death	(Check only				<del>/</del>	
Of V Physic this c	F	2	1 ☐ Yes 2 No	Hospital: 1 X Inp		ER/Outpatien			4 🗆 140		ne 5□Res				)	
ding P After I	9	5	27. Manner of Death 1 Natural 5 ☐ Pending		Day Year)	28b. Time of Injury		8c. Injury Work			8d. Describe	how inju	ry occurred	1		
ISIC ttend death death ctor:	100	2	2 Accident investiga 3 Suicide 6 Could no	t be 390 Place of	Injury - At h	ome, farm, str	M factors		/es 2□		8f Location	(Street as	ad Number	or Pural	Poure Num	bor
UNISION OF VITA To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific cimpletely filled in by the funeral director.	0014161004100		4 Homicide determin	building	, etc. (Specif	<b>(y</b> )					City or To	wn, State	3)			1001,
Lothe Hospitel within 24 hours a Tothe Funerel completely filled	Mode	alcal	(Check only one)  Certifying  (Check only one)	Physician: To the basi caminer: On the basi and manner	s of examina	whadge, death ition and/or inv	estigation,	at the tim in my op	a, date an inion, dea	d place, a th occurre	nd due to the id at the time	date and	) and man d place, an	d due to	ited. the cause(s	<b>s</b> }
To the To the To the Comp	2	E	29b. Signature and title of certifier	, ~ C	N			License				29d. Da	te signed (	Month	Pay, Year)	~
			> dedunger	111/2	hle n	$N \cdot D$	E	241	410			Jonn	ary -	20"	1,20	( )
5			30. Name and address of person w	no completed cause	of death (Iten	п 23а) (Туре,	Print) J	0611	IDE	RP	Mes	ATH	+			
			31. Date filed (Month, Day, Year)	14221	AL C	EMTER	F	AN	DALI	1T2	My C	41/1	0/ 14	1115	ንጋ	
Regi	State istrai		JAN 2, 3 200		istrar's Signa	ature and										
	1/200			San Allend	15 /24	A STATE OF S	9	-								

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of Ma	ıryland				ealth a Death	ind M	F	leg. No.	007	01454
	Physici	an	Decedent's Name (First, Middle, Last	)							Date of Dea     Month	th Day	Year	3. Time of Death
	/Medic		FRANK JOHNSON, JF								01	14	2007	8:20 A <sup>M</sup>
- A	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City,	, Town, or	Location of	f Death		4c. Co	ounty of Death	
			1934 W. FAIRMOUNT		the same to			LTIM	ORE If Under 2	24 Hrs	O Date of Birth		0.8:4	La Catalana Camina
	Funeral		5. Social Security Number 6. Se	x   7.Age S <u>T</u> M 2□F		ast birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth	_
	Director		212-34-7571 Usuaf Residence of Decedent		69_						02/08	/ 193 /		MD
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Mary Hed	ğ	MD		BAT.	TIMORE	:							1 X Yes 2 □ No
	r 28	Director	10e. Street and Number					p Code				log. Citize	n of What Cour	ntry?
	th wit		1934 W. FAIRMOUNT	' AVE.			21	223				USA		
	dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	S. 13. V	Vas Dece	dent of His	spanic Orig	in? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
9	or it	F	1 Never Married 2 Married	1 ☐ Yes 2 🔀 N If Yes, Give	0		1 □ Yes		Specify:			S	pecify: BLA	
21215-0036	d within 72 hours after death with the Maryland jene. r than "neturel", or items 23a or 28e-f ehow the Macical Exeminer count be mullied at	d by	3 ☐ Widowed 4 🖾 Divorced	Year or Dates:										
7	net net	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced (Give	kind of wo		urina most	of worki	ng	160. Kind	of Business/In	austry
12	withii Bne. than	ᇤ	Elementary/Secondary (0-12)  9TH	Coflege (1-4or 5-	+)	SELI		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				COT	T.ECTOR	for RECYCL
	be filed ital Hygi d other event, I		17. Father's Name (First, Middle, Last)			نسان			18. Mother	r's Name	(First, Middle,			101 100102
an	Aental Aental rrked c	To Be	FRANK JOHNSON, SF	•					мΔππ	TE S	AMPLE			
Maryland	Shound M	-	19a. Informant's Name/Relationship (T			19b. Mailin	g Address	s (Street a			l Route Numbe	r, City or T	own, State, Zip	Code)
ž	nd 2 alth a 27 is		PATRICIA HURSEY/F	RIEND		1934	4 W.	FAIR	MOUNT	AVE	BALT	IMORE	E MD	21223
ē,	s 1 a f Hei ttem othe		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Na	me of	I		ate			ELL ST.
E	Pages nent of ant: if th any or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			. CARM	•			01/18	3/2007			
Baltimore,	불투분군		21. Signature of Funeral Service Licens	ee //		-4					LEY CHA			
œ	Depriment of the point of the p		Weskey	Man	4	E					VE., BA			
			23a, Part1. Enter the disease, or comp	lications that caused ne cause on each fin	the death	. Do not ente	er the mod	de of dying	g, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	net	-a.st	4at/c	00	not la	te c	ant	21			Onset and Death
3	/Medical		resulting in death)	Due to (or as a	consequ	ence of):		0010	1	Vace				· gear
н	Examiner		Saquantially list conditions	b										
	p ti	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	ı consequ	ence of):								
	and I-tran	хап		c. Due to (or as a	consequ	ence of):								
760,	ate be executed hysician and the burial-transit	cal E												
687	death certificate L s attending physic d for use as the E			d										
×	death certifica e attending ph id for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of								230	d. Date of delive	erv
Вох	death atte	ciai	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			]Ectopic p ] Other (s <sub>i</sub>						Month	Day Year
P.O.		Physician/Med	9 □ Unknown	9□ Unknown										
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death bu	t not resu	iting in the ur	nderlying	cause give	n in Part I.		23e. Did to	bacco use	contribute to th	ne cause of death?
ğ	w require been sig should b						_				1 🗆 Y	es 2 21	√o 3∏Prob	abiy 4 □Unknown
000	elawre hasbe je 2 sho	Completed									24a. Was a	in 2	24b. Were auto	psy findings available impletion of cause of
œ	The ate h page	E O									perform 1 ☐ Yes	ned?	death?	2□ No
ita	Physician: Tribis certificateral director, pr	Be (	25. Was case referred to medical examiner?							of Death	(Check only or	е)		
7		၉	1 ☐ Yes 2 1 No			R/Outpatien			4 🗆 1401		ne 5 Pesid			y)
Ē	After uners	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of fnjury		28c. Injury Work			28d. Describe h	ow injury o	ccurred	
sic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Pface of Inju	n. At hou	mo form etc	M		res 2□N		29f Location /S	treet and N	lumber or Que	I Route Number,
Division of Vital Records,	after death Director:	Certification;	4 Homicide determined	building, etc.	. (Specify	)	set, Iactor	y, once		1	City or Town		ombor or rigin	i noble wombor,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier 1 (D Certifying Phy (Check only 2 ☐ Medical Exam	sician: To the best o	f my knov	vledge, death	occurred	at the tim	e, date and	d place, a	and due to the c	ause(s) an	d manner as s	tated.
	the He in 24 the Fu	ledical	one)	ner: On the basis of and manner stat		ion and/or inv	-			n occurre				
	To To	Σ	29b. Signature and title of certifier	/				c. License					igned (Month,	**
•	1		Ch Moh	lemon 1			1	1.77	782		V	GALLE	7/8/2	007
d	2		30. Name and address of person who c	ompleted cause of de $240/1$	ath (Item	23a) (Type, I	Print)	1	. 1	1×1	J nur, Ma	. 1.	/ 212	-
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registra	i a Digital	ure p	nee!	17 14/12	14 10	41/10	WY, // Cg	y/ars	1 0/2/	٧
	Registr		JAN 2 3 2007	32. Registra	K	Spark								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JÁNÜARY 20°, 2007 BETTY **JOLSON** 12:17 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 / 10 / 1922 6. Sex Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-16-2133 Director 84 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 2 minportant: If item 27 Is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be none. 7812 RIDGE TERRACE 21208 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ WHITE 3 Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0,12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL HARRIS ANNA ASHKIN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 EAST 87TH STREET - #20-F NANCY JOLSON LEBER / DAUGHTER NEW YORK, NY 10128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/22/2007 HAR SINAI CEMETERY OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying, Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 \(\bar{\text{\text{No}}}\) No 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura! 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. or Attending Physician; Hospital

physician and s the burial-trans

attending pl

the Maryland

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f show diral Examiner must be notified at

To the within 2

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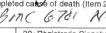
filled Funeral

31. Date filed (Month, Day, Year) State Registrar

29a, Certifier

(Check only one)

29b. Signature and title of certifier



29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) WANUING 20, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print). 6761 N. Charles St. 6-BINC

32 Registrar's Signature

		ľ	1 - For State Registrer	State of N	/larylar				ealth a Death			gienę Reg. No.	2007	01456
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month		Vans	3. Time of Death
ı	Physici /Medic		John W. Jurs								O/	Day 21	200 7	
	Examin		4a. Eacility Name (If not institution, gi Johns Hopkins Buy	ve street and number	r) (enl	ev		Town, or Lifim	Location o	of Death	)		County of Dea	
	Funeral Director			Sex 7.7	Age <i>(In yr</i> s. 94	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)	h ( 9°1°)2	9. Bii	rthplace (State or Foreign country) MD
	pc ,		Usual Residence of Decedent		10- 0									101 1-11 01 1-11
	anylar ehow	L.,	10a. State 10b. County			ty, Town or Lo								10d. Inside City Limits 1 A Yes 2 □ No
	Ba-f	cto	MD		Ва	1timo								
	h with th	ai Dire	10e. Street and Number 3800 Claremon	t Avenue			10f. Zip	1 2 2	4			10g. Citiz US	en of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f ehow any injury or other treumatic event, I'm Medical Examination in the confilled at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 X Yes 2 [ If Yes, Give Year or Dates	s? ] No		Was Dece If Yes, spe 1  Yes	cify Cuba	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)		4. Race - Am Black, Whi	erican Indian, ite, etc. White
21215-0036	turel	ed k	15. Decedent's 1		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	16a Dece	dent's Usu	al Occupa	ation			16b. Kin	d of Business	
75	n ne	piet	(Specify only highest g		« E . \	(Give	kind of wo	ork done d ise retired	luring mos )	t of workir	ng			,
212	r the	Completed	8	College (1-40	1 5+)		Weld	er				Bet	hlehe	m Steel
Maryland ;	id be fited v ental Hygie ked other i c event, tt	To Be C	17. Father's Name (First, Middle, Las George Jurs	t)							(First, Middle, Stops	Maiden S	Sumame)	
ary	shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relationship				ng Address	s (Street a	and Numbe	er or Rura	Route Numbe	r, City or	Town, State,	Zip Code)
	nd 2 alth a 27 is		Katherine Grov	er - Dau	ıghte	380	0 C1	arei	mont	Ave	., Bal	Ltim	ore,	MD 21224
J.	s 1 a of He item othe		20a. Method of Disposition	75 1/ 0		Place of Dispo	matory or c	other place	e)		ate	20c. Loc	ation - City or	Town, State
E	Page nent c int: if		1 ☐ Burial 2 【Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		e Ba	yview	Cre	mate	ory	1 – 24	-07	Ba1	timor	e, MD
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service Lice	ensee							dley-A			neral Hom
r	_		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caus	ed the dea								• • 2 1	Approximate Interval Between
	Physician		Immediate Cause (Final		meni									Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a						-				year
	Examiner		Out and the line and distance	b										
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	is a consec	quence of):								
/	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	c										
Ö,	e exe ian a urial-t	Ä	resulting in death) Last	Due to (or a	is a consec	(uence of):								
8760,	cate be executed physician and the burial-transit	dical		d										
9	e as t	Mec	IF FEMALE:											
Вох	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	aldeath 3[	Ectopic p					23	3d. Date of de Month	livery Day Year
o o	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown (N/A)	4□Pregnant 9□Unknown	at time of c	leath 5∟	Other (sp	овсіту)						
P. 0.	hat the	Ph	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying	cause give	n in Part I.		23e. Did to	bacco us	e contribute t	o the cause of death?
ds,	uires tha signed d be det	d by	(none)					3			1 □ Y	es 2 🗆	No 3□P	robably 4 XUnknown
Ö	w requir been si should	ete									24a. Was a		24h More o	utopsy findings available
Rec	sicien: The law s certificate has b lirector, page 2 s	Completed									autops	sy		completion of cause of
a			on the contract of the contrac								1 Yes	2 <b>X</b> No	1 🗆 Yes	s 2 No
₹	Physicien: r this certificated director,	Ве	25. Was case referred to medical examiner?	Hospital:		1500		Othe	100		(Check only or			
of	Phys r this ral di	- To	1 Yes 2 No	1 ☐ Inpa 28a. Date of In	jury	ER/Outpatier		JA	420 INU		ne 5 Reside			ecity)
on	ding F h. After funer	tion	1 XNatural 5 ☐ Pending	(Month, L	day Year)	Injury	м	28c. Injury Work 1 □ Y	? /es 2 □ l			,,		
Division of Vital Records,	or Attendate death Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determine	28e. Place of J	njury - At h etc. <i>(Speci</i>	ome, farm, str fy)					8f. Location (S. City or Tow		Number or R	ural Route Number,
ئے	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical Ce		hysician: To the beaminer: On the basis										
	the F nin 24 the F	ledi	one)	and manner										
1	Vith To COL	Σ	29b. Signature and title of certifier	<b>.</b>				c. License			2			th, Day, Year)
	1			rp				000	005	, 2		011	21/20	0/
_	2+1		30. Name and address of person who			n 23a) (Type,		B	altiv	nove	MD.	212	24-2	734
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signa	ature	- BR	0						

State

DR. TARIQ MAHMOOD

JAN 2 3 2007

31. Date filed (Month, Play, Year)

Maryland

Baltimore,

Records, P.O. Box 68760

or Vital

Division

JEFFERY

JANUARY

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			_ State	aryland / Dep	ertificate of h		lental Hygie	ene	7 011.59
	B. III.	٠	Registrar  1. Decedent's Name (First, Middle, Last)		er irricate or i	Dealii	Reg	J. No. ← U U	3. Time of Death
	Physici /Media		william line	mer			Month	20 Wo	
	Examir		4a. Facility Name (If not institution, give street and number)  JOHN ( HAOK IM 3 DUI)	. 0	4b. City, Town, or	Location of Death		4c. County of Deat	
Sp	Funeral	- W	10/5/20	1. CW  (In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Cit	thplace (State or Foreign
	Director		216-01-2534 ¹⅓™ 2□ F	86 Yrs.	Months Days	Hours Min.	(Month, Day, ) June 4,1	Co	cyland
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Marylan a-f show fied at	tor	Maryland Baltimore	Dund					1 ☐ Yes 2 XNo
	or 28s	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	puntry?
	sath w s 23a nust k	eral	6803 Duluth Avenue		212.			USA	
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 ★ Yes 2 □ N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp. in, Mexican, Puerto Specify:	ecify Y <i>e</i> s or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
2-0	172 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa e kind of work done of DO NOT use retired	ation during most of work	ing 16	bb. Kind of Business/	Industry
121	within lene. than he Me	ршс	Elementary/Secondary (0-12) College (1-4or 5-12) Years 2 years	+)	DO NOT use retired evenue Of:			. D. C	
מפר	e filed al Hygi other vent, tl	Be C	17. Father's Name (First, Middle, Last)	100	evenue OL		e (First, Middle, Ma	I.R. S. iden Surname)	
ylar	should be and Mental s marked o umatic eve	To E	George Kremer			Teresa M			
Mar	d 2 sho th and 7 is mi traum:		19a. Informant's Name/Relationship (Type. Print)  Betty Mae Kremer wife					City or Town, State, 2	
ē,	of Health item 27	1	20a. Method of Disposition	20b. Place of Disp	Duluth Avosition (Name of ematory or other place		Date 20	c. Location - City or	1222 Town, State
<u>E</u>	Pages nent of ant: If its ury or o		1  Burial 2  □ Cremation 3  □ Removal from State 4 □ Donation 5  □ Other (Specify)	Sacred Hear	rt of Jesus	<sup>e)</sup> Janua 24, 2	ary	undalk,Mai	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee  MTN 6MY  On	nellys	2. Name and Address opnelly Fu 110 Soller	s of Facility ineral Ho s Point	me Of Dur Road, Dur	ndalk, P.A. ndalk, Md.	21222
	**		23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	the death. Do not en	ter the mode of dying	g, such as cardiac o	or respiratory arrest	,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CVD					Onset and Death
	Examiner			consequence of):					
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08/60	icate be executed physician and s the burial-transit		d	concoquence on.					
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C. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive	very Day Y <i>e</i> ar
Ţ.	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	n in Part I	23e Did tohac	co use contribute to	the cause of death?
cords	quires en sign uld be	0	Perlumion's direase					2 No 3 Pro	
000	faw re as bee 2 sho	Completed					24a, Was an	24b. Were aut	topsy findings available
<u> </u>	: The law cate has b page 2 si	ခ မ					autopsy performed 1∐ Yes 2 ∑	death?	ompletion of cause of 2□ No
V II	sician certifi rector	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No Hospital: 1 □ Inpatient		othe	26. Place of Death	, , ,		
0	g Phy ter this neral d	- 1	27. Manner of Death 28a. Date of Injury	28b. Time of	11 3 DOX	4 ☐ Nursing Hor	ne 5 Residence	e 6 Other (Specinjury occurred	ify)
IVISION	tendin eath. or: Af	atio	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury		? es 2 □ No			
		Certification:	4 Homiciae determined building, etc.				City or Town, S		9
	e Hosp 24 hou e Fune etely fi	Medical	29a. Certifier (Check only one)  1 **Excertifying Physician: To the best of 2 ** Medical Examiner: On the basis of e and manner state	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Compl	Me	29b. Signature and title of certifier		29c. License		29d.	Date signed (Month,	, Day, Year)
	9		· Beamanns		DZ	.8684	0	1/20/2	907
<	6		30. Name and address of person who completed cause of dea	3-1	Print)	ob	Ra	1/20/2	
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar'		110	years 3	Day	in	
	Registre		1881 2 2 2007	10 4	F				1

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 17,2007 Year **Physician** JAN. 7:00pM JEANNETTE S. KRIZEK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3404 HARMONY COURT BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 14 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2 F 216-01-2908 92 Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director MD. N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23s or 3404 HARMONY COURT 21224 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: ģ 3 X Widowed 4 ☐ Divorced WHITE 'naturel' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS CLOTHING permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if item 27 is marked othe any linjury or other treumatic event gode. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTHONY BINKOWSKI VICTORIA JAKUBIAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES SMERDZINSKI/NIECE 8213 BUCKNELL DRIVE, VIENNA, VA. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) ST. STANISLAUS CEM 1/22/07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART ATTACK **Physician** innediate /Medical Examiner pe 110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) physician a s tha burial-1 P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ţō Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 21 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cartificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 ☑ No Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by tha fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 135170 31. Date filed (Month, Day, Year)

JAN 2 3 700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 808-810 S. Conkling St PIER 3 Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU/ For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17, 2007 Month January Daniel James Kelley 7:40 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Health & Rehabilitation Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Tune 10, 1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) New York Days 1₹ M 2□ F 069-18-4284 New Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6203 Dunrobbin Drive 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WWI] 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond E. Kelley Helene Tierney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marcy G. Kelley / Daughter 6203 Dunrobbin Dr., Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 20, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2007 Bethesda, Maryland Robert A. Pumphrey rumeral Home/Betheada-Chevy Chase, Inc. 21. Signature of Funeral Service Cicensee 7557 Wisconsin Ave., Bethesda, MD 20814- 3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) NEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Las! Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. After death. within 24 hours after death

To the Funaral Diractor:
completely filled in by the

Physician

Examiner

**Funeral** 

Director

28a-f show

Directo

Completed by Funeral

Be

ortant: If itam 27 is marked other than "natural", or items 23e or 28e-f shot injury or other traumatic event, the Medical Exam as must be notified at

.. Pages 1 and 2 should be fill thent of Health and Mental Hitant: If itam 27 is marked oth

permit. Page Department o Important: If any injury or once.

**Physician** 

/Medical

Examine

Physician/Medical

þ

Completed

Be

2

Medical Certification:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

25. Was case referred to medical 27. Manner of Death 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

00057124

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Medical Center Dr. #201, Rockville, Maryland 20850 Truong Bao, M.D.,

Smo, mo

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 3 2007

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			For State	State o	f Marylar	-					,			. 0 !	1 6 1	
			1 State Registrar  1. Decedent's Name (First, Middle	( act)		Cei	rtificate	OT L	<i>Jeatn</i>		2. Date of De	Reg. No	<u> </u>		401	
	Physici	an	Anna Veronic	,							Month JANUA	Day	y Ye	ar	e of Death	
N. Comments	/Medic Examir		4a. Facility Name (If not institution	. give street and nur	nber)		4b. City, T	own, or	Location o		2 mi40mi		22, 20 County of D		15F M	
			Saint Josep	h Medica	al Cen	ter	Towso				n			Baltimore		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.		If Under 1 Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	th y, Year)	9.	Birthplace (Sta Country)	te or Foreign	
Shar	Director		220-14-0414  Usual Residence of Decedent	, C, W, 2X,	83	Yrs.					July 1	,19	23 1	Maryla	nd	
	/land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside	City Limits	
	a-f sh	ctor	Maryland Bal	timore		Stever	nson							1 □ Y	es 2 No	
	ith the	Directo	10e. Street and Number				10f. Zip C	Code				10g. Citi	izen of What	Country?		
	ath w	ral	1830 Hillsid					115					.S.A.			
	items ner m	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Decede If Yes, specif	ent of His fy Cubar	spanic Ori n, Mexicar	gin? (Spe 1, Puerto F	cify Yes or No Rican, etc.)	-	<ol> <li>Race - A Black, W</li> </ol>	merican Indian hite, etc.		
336	urs af al", or xami	þ	1 ☐ Never Married 2☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Giv Year or Da	e		1 ☐ Yes 2	<b>∑</b> No	Specify:				Specify:	Whit	2	
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12	filed w Hygiel other tl		17. Father's Name ( <i>First, Middle</i> ,	(act)		ļ h	louse	-		de Name	/Cion A. Balindalia		memak	er		
and	ould be f Mental P arked ot atlc ever	Be c	Jack Wilson	Lasij				i			(First, Middle,		Surname)			
Z.	should nd Men marke imatic	2	19a. Informant's Name/Relationsh	nip (Type. Pri <u>n</u> t)	la = I	19b. Mailir	ng Address (	'Street ai			Sween Route Number		r Town. Stati	e. Zin Code)		
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Gabriel A. La	arrimore	band									2115:	2	
ore	of Hez of Hez if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from 9		Place of Dispo cemetery, crer	sition <i>(Name</i>	e of	1	Da	ate	20c. Lo	cation - City	or Town, State		
Ë	permit. Pages . Department of P Important: If Ite any injury or of		4 □ Donation 5 □ Other (S)	pecify)	Met	tro Cr							altim	ore, N	1d.	
Bal	Depar Depar Impor any in		21. Signature of Funeral Service	Licensee		22	2. Name and	Address	of Facilit	y Eck	hardt	Fu:	neral	Chape	el P.A	
	200		23a. Part1. Enter the disease, or	complications that or	aused the deat								ings	Mills		
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ta	ilclan: Th certificate rector, pag		25. Was case referred to medical						OC Dises	-1 D11		med?	1 🗆 Y	es 2 No		
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	10		30. Name and address of person v	vho completed cause	e of death (Iten	n 23a) (Type, I	Print)							-		
	6		BOON POH LIM.			SLER D	RIVE	T	OWSO	N. M	IARYLA	ND :	21204			
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29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	<u>io</u>	nding th. : Afte	atio		ing	(Month, Da	y Year)	Injury				lo			,			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				1 Curait	Sun	$\sim$		m, 10	1	25	450	2		10	- 19		TODE	
1/ Cristal Simpson		) )		30. Name and address of person	who completed	cause of	death (Item	1 23a) (Type,	Print)					<u> </u>				_
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		- 1	Registrar  1. Decedent's Name (First, Middle, L.	ast)		Cei	uncate of t	Jeath	2. Date of Dea	Reg. No	3. Time of Death
	Physici /Medic		Anth		Live	olsi			January	19,200	Veer
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of D	eath	4c. County of	
			15 Greenridge F		7 Bee //p use lead h	Parkles alles a N	Luth If Under 1 Year	ervill			altimore
	Funeral Director		,	Sex 1DAM 2□F	7. Age (In yrs. last b. 94	Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Day Nov. 7,	r. Year)	9. Birthplace (State or Foreign Country) Maryland
421	D		Usual Residence of Decedent		10c. City, Tov					1510	
	faryla shov	ō	10a. State 10b. County Maryland Baltimo				/ille				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-i	Director	10e. Street and Number	)	Lut	лег	10f. Zip Code			10g. Citizen of W	/hat Country?
	th witl	al D	15 Greenridge F	Road			210	93		U.S.	Α.
	er dea tems ier mi	Funeral	11. Marital Status	Armed Fo	edent Ever in U.S. rces?	13. \	Vas Decedent of H f Yes, specify Cuba	spanic Origin' n, Mexican, P	? (Specify Yes or No- ruerto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □XYes If Yes, Giv Year or Da	2 No e1942-1945		I∐Yes 2∭XNo	Specify:		Specify:	White
21215-0036	72 hou natura lical E	Completed	15. Decedent's E (Specify only highest gi	ducation		a. Dec <i>e</i> c	lent's Usual Occup	ation	working	16b. Kind of Bus	
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d 2	Hyg the nt,	o Co	12   17. Father's Name ( <i>First, Middle, Las</i>	it)		MI	usician	18. Mother's	Name (First, Middle,		INdustry
Maryland	@ C = 0	To Be	John	Livols	i				Santina		titta
lary	2 should and Men is marke aumatic	7 1	19a. Informant's Name/Relationship		19	b. Mailin	g Address (Street a	and Number o	r Rural Route Numbe	r, City or Town, S	State, Zip Code)
	s 1 and 2 should of Health and Men item 27 is marke other traumatic		Antoinette Livols 20a. Method of Disposition	si Daug	ghter 1	5 G	reenridge	_Road	Luthervi		cyland 21093 Dity or Town, State
Baltimore,	00		MBurial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	Removal from	State		sition (Name of natory or other plac Faith	i i		Rossvill	
altin	- E # E		21. Signature of Funcial Service Lice	* -	darden	-	. Name and Addres				e Maryland al Home, Inc.
ä	permi Depar Impor any Ir once.		HOLLER	gan			1050 Yor		Towson	, Maryla	nd 21204
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cay one cause on e	aused the death. Do ach line.	not ente	er the mode of dyin	g, such as car	diac or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ac	UTE GA or as a consequence		DINTEST	INAL	BLEEDIN	06	I DAY
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<u>o</u>	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□Unkno	ant at time of death	5	Other (specify)			l won	ur Day roa
Δ.	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions	contributing to de	ath but not resulting	in the ur	derlying cause give	n in Part I.	23e. Did to	bacco use contril	bute to the cause of death?
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Or	ding Phy: h. After this funeral di	$\vdash_{f}$	27. Manner of Death	28a. Date of	of Injury 28b.	Time of Injury	28c. Injury Work		ng Home 5 Reside	ow injury occurre	
sior	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	on	ii, Day Year)	injury		res 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could not to 4 Homicide determined	20e. Place	of injury - At home, fang, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Numbe n, State)	r or Rural Route Number,
	spital		29a. Certifier 1 Certifying P	hysician: To the	best of my knowledg	e, death	occurred at the tim	ne, date and pl	lace, and due to the c	ause(s) and man	iner as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	mlner: On the ba and manr	asis of examination a ner stated.	nd/or in\			occurred at the time, o	late and place, a	nd due to the cause(s)
	To To	2	29b. Signature and title of certifier	1	) ha c	`	29c. License	32.7	2	9d. Date signed	(Month, Day, Year)
	nxi		30. Name and address of person who	completed cause	e of death (Item 23a)	(Type '				01/11	12007
	5	_	LOIS E. NIEL:		10; 120	515	TER PIL	ERRE	DR, #20	6; TOU	usal, mo
	Sta	te	31. Date filed (Month, Day, Year)	07 32 R	ėgistrar's Signature	Ana	200				21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per doc 10e per fb 9863 1-31-07 vt. State of Maryland / Department of Health and Mental Hygiene)

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Month Edythe J. Larsson January 21, 2007 6:15 A. /Medical 4a Facility Name (If not institution, give street and number 125 719 Maiden Choice Lane Ant BR61 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Yrs Director 94 522-24-8525 Sept. 22, 1912 Minnesota Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 1 No Funeral Director Maryland | Baltimore Catonsville 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? **RGN 225** 719 Maiden Choice Lane Apt 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 Ho Specify: 2 Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home or other traumatic avant, permit. Peges 1 and 2 should be flik Department of Heelth and Mental Hy Important: if itsm 27 is marked oth any linkry or other traumatic avant 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Oscar W. Johnson Anna Ahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Warren Son-in-Law 163 Woodlawn Street; Hamden, CT 06517 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/26/2007 Garrison Forest Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** meumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physicien: The law requires thet the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy deteched for Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sete has been sign page 2 should be Dysphagia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 ₽No completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death | Check only one Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Aftert 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44377 even 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 maidon Choice Lane, Catensville, mn 21228 Bowlin mo 31. Date filed (Month Day, Year) JAN 2 3 3 Registrar's Signature State Registrar

lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fh 8863 1–23–07 yt.

State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JÄNÜARY 19, 2007 1:45 P LEVIN LEONARD /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/15/1921 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min. Director 85 V٨ 220-07-5016 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 7421 KALTON COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE WWII Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MERCHANT VARIETY STORE permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie
Important: If Item 27 Is marked other t
any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL LEVIN SARAH BAER ္က 19a. Insuman's Name/Relationship (Type: F WELLYN JEAN LEVIN / WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7421 KALTON COURT - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MEN CEM | 01/22/2007 WOODLAWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Concer UNG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 Yes 2 No 1 Inpatient မှ 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Balto. Md 21708 10 63me 6701 gistrar's Signature 32. 31. Date filed (Month, Day, Year) State JAN 2 3 2007 Registrar

	1	For State Registrar	State of Marylan		artment o				jiene 0	07	01466	
Physicia		Decedent's Name (First, Middle, Last)						2. Date of Dea Month Januar	Day	Year 2007	3. Time of Death  6:45P	
/Medica	1	Alma A. Miller  a. Facility Name (If not institution, give str	4c. County									
		8404 Harris Aver Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 \	Year If	more Under 24 Hrs.	8. Date of Birth (Month, Day			lace (State or Foreign try)	
Funeral Director		219-22-5343		31 <sub>Yrs.</sub>	Months D	Days F	lours Min.	10/24	/1925		land	
land ow	}	Suel Residence of Decedent  Oa. State 10b. County	10c. Cit	y, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2∕0€0	
e Mary	cto	MD Baltimo	ore	I	Baltin				10g. Citizen of	What Cour		
death with the Maryland ms 23e or 28s-f ehow rmust be notified at	Dire	0e. Street and Number 8404 Harris Ave	e.		10f. Zip C	2123	4		US			
5 £ 5	Funeral Director		. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 3€7No		Was Deceder If Yes, specify		unic Origin? (Spe Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White,		
hours after turel; or the	ò	3€ Widowed 4 Divorced	If Yes, Give Year or Dates:		dent's Usual					6b. Kind of Business/Industry		
d within 72 hours af gjene. or then "natural", or the Mudical Exam	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ng most of worki	ng		erchantile ountry Club						
be file tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last) George Masek		1			. Mother's Name		Maiden Sumai Krume			
d 2 should th and Men ?7 le marke traumatic	ဥ	19a. Informant's Name/Relationship (Typ	, State, Zij									
Hea Hea	-	David Miller—  20a. Method of Disposition  M3Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b.	Place of Disp	003 An osition (Name omatory or oth 1 Vall 1 Gar	of er place)	\.Tanu	ary	nore, I 20c. Location Timor	- City or T	own, State	
permit. Pages 1 at Department of Hea Important: If Item eny injury or oths		O Hai	larford Rd. e, MD 21234									
Dhysisian			Approximate Interval Between Onset and Death									
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Cele 6.3 (Met 45.78.88.5)  Due to (or as a consequence of):										
uted d ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
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death certifica death certifica e attending ph	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 № No 9 □ Unknown	3c. If yes, outcome of preg 1 □Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pre					Date of deliveration	very Day Year	
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SIOF tendin leath. tor: Af the fur	Certification	1 Accident 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, farm,	М	1 🗆 Y	s 2□No	28f. Location City or To	(Street and Nur	mber or Ru	ral Route Number,	
<b>2 3 3 3 3 3</b>		4   Homicide	building, etc. (Spe sician: To the best of my k ner: On the basis of exam	rnowledge de	ath occurred	at the time	o, date and place	and due to the	e cause(s) and	manner as e, and due	stated. to the cause(s)	
To the Hospital or within 24 hours after or To the Funeral Directory completely filled in	Medical	29b. Signature and title of certifier	and manner stated.	manon anwor		: License		22 23 330 3316	29d. Date sign			
10		30. The an address of erson who co	ompleted cause of death (I	tem 23a) (Typ	pe, Print)	200	264	75	1/22	10	7	
1		31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature	7	0/2	- 118	1000	KOSO	Χ		
St Regist	ate rar	JAN 2, 3 20	1	B. A	perte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U U / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Christo Pher 16 2007 (ou) January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOSPITAL Butimore, (
If Under 1 Year | If Under 24 Hrs. iT 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
4 Ohio 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 10 M 2 F 215-60-9744 53 1954 Director January 6, Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medikal Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2X No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5868 Whisper Way 21075 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√TVNo Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Publishing 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald James Marlow Shirley Collier ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Marlow (mother) 5868 Whisper Way Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) Metro Crematory 1/18/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge, Maryland vans Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GOSTRIC days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine · this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 spital or Attending Pl lours after death. neral Director: After t' y filled in by the funera funeral 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 D Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of cortif 29c. License number RES-000 STANWIX IMD

Registrar DHMH 17 Rev 1/2001

State

DORTH

600

wolfe St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW

31. Date filed (Month, Day, Year)

STA PW Z

	1	For State Registrar	State of M	1arylaı		artmen rtificat				R	eg. No.	007	011	168
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Las  THELMA SOPHIE MARI  4a. Facility Name (If not institution, give LOCUST LODGE 184 MEADOW RD.	E MASON	r)		4b. City,		Location of	J	Date of Dea Month ANUARY	22 4c. Co	Year 2007 unty of Death		
Funeral Director		5. Social Security Number 6. Sec. 11 215.07.6794 Usual Residence of Decedent	7. A	ge (In yrs	. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	Date of Birth (Month, Day EBRUARY	(Year)	Col	place (State of untry)  DE	or Foreign
if Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at To Re Completed by Funeral Director		10a. State 10b. County  MD ANNE ARUN  10e. Street and Number LOCUST LOGGE  184 MEADOW RD.	DEL		ity, Town or Lo	10f. Zip				1	0g. Citizen	of What Cou		ity Limits 2 No XX
ural', or items 2:	2	11. Marital Status 1 □ Never Married 2 □ Married 3 ★★Widowed 4 □ Divorced		Was Deced If Yes, spec	dent of His cify Cubar	Specify:	in? (Specify Puerto Rica	y Yes or No- an, etc.)	o· 14. Race - American Indian, Black, White, etc.  Specify: WHITE					
ygiene. ner than "naturit, the Medical I	and in or	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	life.	dent's Usua kind of wo DO NOT us	rk done di se retired)	uring most	of working		16b. Kind of Business/Industry  HOSCHI LD-KOHN					
Mental Hygnarked other natic event,	2	17. Father's Name (First, Middle, Last)  CHARLES KAMMERER				ROSE I	BELL	irst, Middle,						
r Health and Item 27 Is m other traum		19a. Informant's Name/Relationship (7  DEANNA MASON JOHNSON 20a. Method of Disposition	DAUG		25326	ADAMS	LAND	ING RD.		N, MD 2	1629	own, State, Z		
Depertment of Health a Importent: If Item 27 is any injury or other tra		XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licents)	)		EN HAVEN	CEMETE 2. Name an	RY d Address	1.	.25.200	7	GLEN	BURNIE	, MD	
hysicien and line burial-transit animas line burial-transit animas linea Examiner	100	23a. Part . Enter the disease, or company, or heart failure. List enter disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Outer Due to (or a  b. Due to (or a  c. Due to (or a  d.	s a conse	quence of):	z Ca	ndi	Vien	cular	DRS	ase		Interval Bet Onset and	
been signed by the attending physicien and should be detached for use as the burial-transit leted by Physician/Medical Examir	ysicial filler	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1								23d.	23d. Date of delivery Month Day Ye		
an signed build be deta	2	Part II. Other significant conditions co									tobacco use contribute to the cause of death?			
r. page 2 should										24a. Was a autops perform	opsy prior to completion of cause o death?			
within 24 hours arter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Compl	2	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending investigation  3  Suicide 6  Could not be determined.	f 2	28c. Injury at Work? M 1 Yes 2 No					Residence 6 Other (Specify) 17557, LiVing be how injury occurred					
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical Certification:		28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street, City or Town, Street)  29a. Certifier  (Check only  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date										State)		
To the Fune completely file		29b. Signature and title of certifier	Buddanner s	stated.		290	. License	number		2	9d. Date si	gned (Month		
3 State Registrar		30. Name and address of person who of STOPHO 3 31. Date filed (Month, Day Year)  JAN 2 3 20	dels 32. Regis	trar's Sign	37	08/	nou	nta	in	Rd.	Pa	Sider	Va Me	1311

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar	State of Ma	aryland /			t of Health of Dear			ene g. No.	07	01469
	Dhusisi	-	1. Decedent's Name (First, Middle, Last,	)						2. Date of Death		Year	3. Time of Death
	Physici /Medio		JOHN		C.		M	ADISON	1	Jan.	Ty,	2 0 0 7	8:20 a
	Examir	er	4a. Facility Name (If not institution, give				4b. City,	Town, or Location	on of Death		4c. Cour	nty of Death	
			1714 Riggs A			:		timore					
	Funeral		5. Social Security Number 6. Se 113-28-8110	M 2□F	e (In yrs. last i	Vrs.	If Under Months	Days Hour	der 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthpl Coun	ace (State or Foreign try)
	Director		Usual Residence of Decedent	7	75	113.				12-15-	1931		MD
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation					10	Od. Inside City Limits
	Man,	to	MD		BALT	IMOR	E.						1 Yes 2 No
	r 28g	Director	10e. Street and Number				10f. Zip	Code		10	g. Citizen o	of What Coun	try?
	23a o		1714 RIGGS AVENUE				2	21217			US	Α	
	within 72 hours after death with the Maryland one. than "natural", or items 23s or 28s-f show he Medical Examiner musi Le notified at	Funeral		12. Was Decedent E Armed Forces?	ever in U.S.	13.			Origin? (Spe	ecify Yes or No- Rican, etc.)	14. R	lace - America lack, White, e	
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2-003e	ural'.	d by	3 Widowed 4 Divorced	Year or Dates:							Spec	BLA	CK
ņ	"nat	ompleted	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16	Sa. Deced	tent's Usua kind of wor	I Occupation k done during π e retired)	nost of worki	ing 1	6b. Kind of	Business/Ind	lustry
7	within Bne. than	щ	Elementary/Secondary (0-12)	College (1-4or 5		LABO		e renieu)			CONS	TRUCTI	ON
0	be filed within 72 hours after death with the Marylan stal Hygtiene. od other than "natural", or liems 23a or 28a-f show of other than "natural", or liems 23a or 28a-f show avent, the Medical Examinar must be notified at	e C	17. Father's Name (First, Middle, Last)			LIADO	KLIK	18. Mc	other's Name	(First, Middle, M			
and	ld be ental ked o	To B	HOBART MADISON										
چ	should be nd Menta marked	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19	9b. Mailin	g Address	(Street and Nur	nber or Rura	I Route Number,	City or Tow	m, State, Zip	Code)
<u> </u>	and 2 saith a n 27 is		GLORIA FOSTER/NIEC	CE		1714	RIGO	S AVE.	BALT	IMORE, M	D 21	217	
ย์	s 1 a f Hea ltem othe	1 1	20a. Method of Disposition		20b. Place	of Dispo	sition (Nam	le of				n - City or To	wn, State
Ē	Pages nent of int: If It		1 ☐ Burial 2 🏋 Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	METRO		•		1-20	-2007	BALTI:	MORE.	MD
allimor	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic once.		21. Signature of Funeral Service Licens	99		22	. Name an	d Address of Fa	cility JAM				F.H., INC.
מ	8958		James G	Mer	tim			I LAURE					1217
			23a. Part1 Enter the disease, or compleshow, or heart failure. List only or	ications that caused ne cause on each lin	the death. D	o not ente	er the mode	of dying, such	as cardiac o	r respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Тур	e 2 D:	iabe	tes						Onsezed Deaths.
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):							
		er	Sequentially list conditions.	). — Due to lor as	2 0000 - 1/000	a offi							
	led sit	nlne	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consaquane	e uil.							
	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a	a consequenc	e of):						_	
0/0 0	icate be executed physician and s the burial-transit	dical		4								ĺ	
000	ifficate g phys as the	(a)		,	-								
X D D	The law requires that the death certificate has been signed by the attending is age? Should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome		th all	Estacia es				23d. C	Date of deliver	у
-	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant at			Ectopic pre Other (spe				N	Month I	Day Year
5	at the by the	hys	9 🗆 Unknown			_							
ກົ	es th igned be de	by	Part II. Other significant conditions con Hypertension		at not resulting	in the ur	nderlying ca	iuse given in Pa	irt I.				e cause of death?
2	een s	ted	Hyperlipdemia							1 🗆 Yes	2 ∐ No	3 Proba	ıbly 4 □Urlknown
Records,	law lasb e2st	ompleted								24a. Was an autopsy	1	prior to com	sy findings available inpletion of cause of
		Co								perform 1 Yes 2		death? 1 🗆 Yes	2 □ No
VII	yslcian: This certificate director, pag	Be	25. Was case referred to medical examiner?	fospital:						(Check only one			
ō	Phys this ral dii	. To	1 ☐ Yes 2 ☐ No X 27. Manner_of Death	1 ☐ Inpatie		Outpatien  Time of		A Curer. 4 🗆		ne 5 □ Resider 28d. Describe hov			)
0	ding Phy th: After this funeral o	tlon	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year)	Injury	M	Work? 1 ☐ Yes 2		LOG. Describe nov	v injury occi	unea	
UNISION	Attend death octor: by the	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ıry - At home,	farm, stre	eet, factory,			28f. Location (Stre	et and Nun	nber or Rural	Route Number.
5	al or	Certification:	4 Homicide	building, etc	(Specify)					City or Town,	State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filed in by the funeral director,		29a. Certifier 1 Certifying Phys	sician: To the best of	f my knowled	ge, death	occurred a	it the time, date	and place, a	and due to the cau	use(s) and r	manner as sta	ited.
	he Hu n 24 he Fu pletel	edical	(Check only 2 Medical Examination)	ner: On the basis of and manner sta	examination a ted.	and/or inv	estigation,	in my opinion, o	leath occurre	ed at the time, dat	e and place	e, and due to	the cause(s)
	To t	Σ	29b. Signature and title of certifier				29c.	License numbe		29	_	ned (Month, D	
	_		Thomas w	Jun "	<b>1</b>			D4005	) <del>)</del>		Jan	. 22,	2007
	2		30. Name and address of person who co	mpleted cause of de	eath (Item 23a	) (Type, I	Grent)	ene St	reet	, Balti	more	, Mar	yland
	V		31. Date filed (Month, Day, Year)										21201
	Sta Registr	_	o. Date med (Month, Ddy, 1981)		r's Signature	<i>u</i>	Land						
			JAN 2 3 2	007	we d	-							

07-00428 Blake A. Myers		Ple		or Print in Bl					-	-	gible.		
Diake A. Wyers		I- For State	State	e of Maryland			e of Death	iu iviei	пат пудп		a No	200	7 01470
Physicia	n/	Registrar  1. Decedent's Nam		ast)						ate of Deat		Year	3 Time of Death
Medical Examin		Blake A. M		ive street and number)			4b. City, Town, o	r Location		Month anuary 15		ounty of Death	1838 hrs
			ongah <b>e</b> la Driv				Rockville		- D Gui			ntgomery	
Funeral	- 1	5 Social Security N		Sex 7. Age	e (In yrs. Ia		y) If Under 1 Yea		A THE SAME OF		•	Foreig	thplace (State or
Director	L	208-42-63	117	M 2 F	50	)	Yrs.	ys Hour	S WIIII	arch 21	, 195	6 co	untry) PA
any	ŀ	Usual Residence o 10a. State	f Decedent 10b. County		10c. City,	Town or I	ocation						10d Inside City Limits
show a	٦	PA	Ourberlan	rd	Sout	h Miđ	illetan Townsh	uip					1 Yes 2 No
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ÖİĞ	10e. Street and Nu 9 Raylen Dr					10f. Zip Code 17007			10	USA	n of What Cour	ntry?
th with	eral	11. Marital Status  1 Never Marri	ed 2 X Marrie	12. Was Decedent Armed Forces?		S 13	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>				14	. Race - Ameri White, etc.	can Indian, Black,
er deat	F.	3 Widowed		1 Yes 2	No		1 Yes 2 X No	n snecify	**		Sn	ecify <b>Whit</b>	<b>a</b>
urs aft (ural"	a p			or Dates: only highest grade con	npleted)	16a. Dec	cedent's Usual Occupa	ation (Give	kind of work	done		d of Business/I	
036 ithin 72 ho ne. r than "na	ompleted	Elementary/Second 12	ondary (0-12)	College (1-4 or 8	5+)		ing most of working life termaster				บร	Navy	
15-0 filed w all Hygie ed other	ပ၂	17. Father's Name Marlin E		st)					ty J.			irname)	
212 212 Muld be Menta mark	o Be	19a Informant's Na	_	(Type, Print )			Mailing Address (Stre	et and Nu	mber or Rural	Route Num	ber, City		, Zıp Code)
MD d 2 sho lth and n 27 is		Christin		ers			rchard Ave						
nore, ges land tt of Heal tt. If iten			Cremation	Removal from St		crematory	isposition (Name of co or other place) FH & Cremet	-	1/19/2	nte 2007		cation - City or	Town, State
mit Pa partmen		4 Donation 5 21. Signature of Fu	Other Speci										
	Ц			ans Ira.			Parkville 88	300 Hai	rford Ro	l. Park	zille,	MD 2123	ion Services 4
Physician /Medical			ne disease, or cor nly one cause on						cardiac or res	spiratory arre	est, snock	, or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause or condition result		Due to (or as a cons			onic alcohol	use					
	er	Sequentially list co		b. Due to (or as a cons	equence o	f):							-
	Examiner	(Disease or injury events resulting in	that initiated	c. Due to (or as a cons	equence o	f).							
executed an and al - transit				d									
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68760, certificate buding physics as the bu	an/Medical	IF FEMALE: 23b. Was decedent past 12 month		23c. If yes, outcome 1 Live birth	me of preg	nancy 2	Fetal death 3		ic pregnancy			Oate of delivery onth	y Day Year
Box 68760, edeath certificate be the attending physici of for use as the buring for use	Sici	1 Yes 2		wn 9 Unknown	time of de	eath 5	Other (Specify)				İ		
O. B. at the de d by the etached f	Phy	Part II. Other sign	ificant condition	s contributing to deat	h but not r	esulting ir	the underlying cause	given in P	Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
ires that signed by the deta	d by									1 Yes	2 N	No 3 Prot	pably 4 V Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should	Completed								- 111	24a. Was autop	sy	prior to o	itopsy findings available completion of cause of
Rec The la cate h	Com									1 ✓ Yes	rmed? 2 No	death? 1 ✓ Ye	es 2 No
ital Recician: The certificate	Be (	25. Was case refe examiner?	rred to medical	Hospital:	ent 2	5D/0.44		Other <sub>4</sub>	(Check only		<u> </u>	0 4 00	0
J of Vii ding Physic After this	<u>٦</u>	1 Yes  27. Manner of Dea	2 No	28a. Date of Inju	ury		atient 3 DOA ne of Injury 28c. Inj	jury at Wor	Nursing Herk? 280	d. Describe		e 6 🗸 Othe	r: Scene
ion c tending eath tor: Af the fun	tion	1 X Natural 2 Accident	5 Pending		rear)		1	Yes 2	_ No				
Division tall or Attendir as after death	Certification:	2 Accident 3 Suicide	6 Could n	ot be 28e. Place of Ir	njury - At h	ome, farm	n, street, factory, office	building, e	etc. 28f	Location (S or Town, S		Number or Ru	iral Route Number, City
Div Hospital o 24 hours af Funeral D		4 Homicide 29a. Certifier		ician: To the best of m	v knowled	Ine death	accurred at the time	date and n	lace and due	to the caus	se(s) and r	manner as stat	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciau: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built	Medical	(Check only one) 2		ner:On the basis of exa and manner stated									
	Ž	29b. Signature and	d title of certifier	Lann	)			nse numbe .M.E.	r			ite signed (Mo	
Ox		30. Name and add		no completed cause of							<u>L</u>		
	tate	Carol Allan 31. Date filed (Moi	·	stant Medical Exa	miner ar's Signat		enn Street, Baltir	nore, Mi	D 21201				
Regis			JAN23	2007	w.	R.	- Janes						
Company of the State of the	and the same					All the Land	****						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) P.M**Physician** 3:13 JANUARY 20, 2007 MARTINEZ ANTONIO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Nov 27, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F Maryland 79 Yrs. 1927 215-24-1546 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a State 10b. County 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Harford Forest Hill Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21050 USA 23a 1771 Pleasant Valley Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or Items Black White etc. TixYes 2 No 1950 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 1953 3 ☐ Widowed 4 ☐ Divorced þ Year or Dates: "natural", 16b. Kind of Business/Industry Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CSX Railroad Secretary 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Mary Berdalls Antonio C. Martinez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1771 Pleasant Valley Road Forest Hill, MD 21050 Penny Martinez, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/23/07 Baltimore. Maryland 21. Signature of Funeral Service Lifensee
Thomas Gregor <sup>22</sup>Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final severe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 6876がく that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown the 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 20 No 3 Probably 4 Unknown 1 Tyes been : 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has 1 Yes 2 NO certificate Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō within 24 hours a To the Funeral L To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

DR. MANUEL LAZATIN

30. Name and address of person who completed cause

29b. Signature and title of certifie

LAW STREET 8 32. Registrar's Signature parti

death (Item 23a) (Type, Print)

and manner stated

15

29c. License number

ABERDEEN,

29d. Date signed (Month, Day, Year)

21001

MD.

07-00352

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Morrissey		Sta 1- For State Registrar	te of Maryland		tment of <i>ficate of</i>		d Mental H		teg. No. 2 1	07 014	7
Physicial Medical Examin		Decedent's Name (First, Middle,  John	Last)		•	Manniaga	75	2. Date of Dea Month January 1		3. Time of Death 1210 hrs	-4-
Maria Maria		4a. Facility Name (if not institution,	give street and number	)		Morrisse b. City, Town, or		th January I	4c. County of	f Death	
Funeral	4	414 Elrino Street  5 Social Security Number 6	Sex 7. Ac	ge (In yrs last	hirthday)	Baltimore If Under 1 Yea	r If Under 24H	re 8 Date of Pi	dh Ann Dagaga	N/A	
Director		100 50 0005	XM 2 F	46	Yrs	Months Day				9. Birthplace (State or Foreign Pennsyl V Country)	/an
any	- 1-	10a. State 10b. County	<del></del>	10c. City, To	own or Location	on				10d Inside City Li	mits
rland -f show	٥	Maryland N/A		Bal	timore					1 X Yes 2	No
c death with the Maryland or items 23a or 28a-f show any must be notified at once.	Ö	10e. Street and Number 414 Elrino St	reet			10f. Zip Code 21224		1	Og Citizen of Wha	at Country?	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Fune	11 Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divor			If Ye	s, specify Cuban	, Mexican, Puert	Specify Yes or No to Rican, etc.)	White,		
ours aft	g p	15. Decedent's Education (Specific	or Dates:	npleted) 1	6a. Decedent	Yes 2 X No	ion (Give kind of	work done	Specify: \		
Ç1 1.	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)		st of working life.				,	
-003 d withi	Ĕ.	12 17. Father's Name (First, Middle, L.	ast)		(	Customer			Govern Maiden Surname)	nment	
215 be files intal Hy rked o	ge Be	John	*	Morriss	sey	Sr	Lorra		D Muri	ohv	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiner.	]٩	19a Informant's Name/Relationship Thomas Boylan	(Type, Print)		19b. Mailing		t and Number or	Rural Route Nun	mber, City or Town,	, State, Zip Code)	
e, M 1 and 2 Health item 2	-	20a Method of Disposition	Brother i	20b. Pla	ce of Disposit	ion (Name of cen	Lane Cr netery,	nerry Hi Date		003 City or Town, State	
MOF Pages nent of ant: If		1 Burial 2 X Cremation 4 Quantion 5 Other Spec			matory or othe sdale (	erplace) Crematori	v   1,	/20/07	Lansdale	ο PΔ	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other tranmatic event, the Mental injury or other tranmatic event.	Ī	21 Signature of Funeral Service L	ensee		22. <b>N</b> a	ame and Address	of Facility St	allings	Funeral	Home P.A.	_
Physician	+	23a. Part I. Enter the risease, or co	m it ations hat caused	the death. De	311 o not enter the	1 Mountage mode of dying,	ain Roac	d Pasado	na MD 211	122	rval
/Medical Examiner	1	Immediate Cause (Final disease	a Narcotic							Between Onset a Death	
	- 1	or condition resulting in death)  Sequentially list conditions,	Due to (or as a conso								
	in in in	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):						17:	
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50, te be executed ysician and burial - transit	Medical	X UNPENDED	AMENDED	Ba 27 28	a-f ner	ME, g863,	1/20/07				
68760, certificate be executed nding physician and se as the burial - transi	Z Me	F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregnar	ncy	-	_		23d. Date of de		
Box 687 e death certific: the attending p ed for use as th	Siciany	past 12 months?  1 Yes 2 No 9 Unkno	4 Pregnant at	time of death	_ =	al death 3 [ er (S <i>pecify)</i>	Ectopic pregn	апсу	Month	Day Year	
that the death certificate ned by the attending phy detached for use as the the	Pnysic	Part II. Other significant condition	9 Unknown	h but not resu	Iting in the un	derlying cause gi	iven in Part I	23e Did to	bacco use contribu	ute to the cause of death?	_
P.C	2									Probably 4 Unknow	
cords, F aw requires nas been sig	Completed							24a. Was a		ere autopsy findings availa or to completion of cause of	
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Vital Rec ysician: The l his certificate l director, page	e l	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2 FE	R/Outpatient		of Death (Check Other Nursi		Davidana C. d	Other	_
ion of Vi		1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Y	ıry 28	Bb. Time of Inj		y at Work?		Residence 6 🗸		-
Sion vitendi death ctor: / y the fi	atio	1 Natural 5 Pending 2 Accident Investig	Fnd 1/12/	′2007	End 12:0	U prit	es 2 X No	unknown			
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death reral Director. After this certificate has been signed by filled in by the funeral director, page 2 should he detach		3 Suicide 6 X Could n 4 Homicide determi	or be	jury - At home esidence		factory, office bu	-	28f. Location (S or Town, Si Baltimore	street and Number tate) 414 E	or Rural Route Number, C Inino Street	ity
	<u>ē</u> [	29a. Certifier 1 Certifying Physone) 2 Medical Examin	ician: To the best of mer: On the basis of exar	y knowledge, mination and/	death occurre or investigation	ed at the time, dat on, in my opinion,	te and place, and death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due	s stated to the cause(s)	
	2	29b. Signature and title of centifier	00 118			29c License				(Month, Day, Year)	
V KILIA		Muia Mas 30. Name and address of person wh	sell M. E	ath /ltom 00	2)	O.C.N	/I. ⊑.		January 13, 2	2007	
7 6			Assistant Medical		,	nn Street, Ba	altimore, MD	21201			
Stat Registra	~	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	1					· · · · · · · · · · · · · · · · · · ·	$\dashv$
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OCME 2006				•							

07-00424 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Mathis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 15, 2007 Medical Examiner Year 1835 hrs Richard Mathis 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1617 Ashburton Street Baltimore 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or Months Days Director Hours Min 214-40-7785 Country) MD Yrs 64 Aug 29, 1942 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits 28a-f show MD 1 X Yes 2 No or items 23a or 28a-f sho must be notified at once. Baltimore 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 1617 Ashburton Street USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes 3 Widowed Yes 2 X No specify: 4 Divorced If Yes, Give Year ģ Specify black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry Completed during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene
7 is marked other than "1
1 atic event, the Medical E Baltimore, MD 21215-0036 Drapery Maker 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Charles Mallard Mathis Mary Elizabeth Rice ဂ္ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages I and 2 sh Department of Health and Important: If item 27 is injury or other tranmat Dorothy Hunt/sister 4800 Yellow Wood Ave. #716 Baltimore, MD 21209 20a. Method of Disposition 20b Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State X Donation 5 Other Specify 21 Signature of Funeral Service License 22. Name and Address of Facility Anthony D. Pleasant State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED attending physician or use as the burial #23a,27,perME, g863, 1/26/07 TT Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Month Day Year Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown been sign hould be Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page certificate Yes 2 Yes No ~ 25. Was case referred to medical 26. Place of Death (Check only one) Be Other<sub>4</sub> Inpatient DOA Nursing Home 5 Residence 6 ✔ Other Scene 2 ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d Describe how injury occurred 28b Time of Injury 28c. Injury at Work? Certification:

Division of Vital Records, P.O. To the Hospital or Attending Physician: After this To the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifie

mos

29c. License number

O.C.M.E.

Yes 2 No

29d Date signed (Month, Day, Year) January 16, 2007

28f. Location (Street and Number or Rural Route Number, City

or Town, State)

30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

5 Pending

6

Investigation

Could not be

determined

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State 3 2 Registrar

1 X Natural

Accident

Suicide

Homicide

2

3

one)

Medical

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death Day 20 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Januar Moser 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltmore Hospital Johns Hopkins If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Country) Switzerland 7. Age (In yrs. last birthday) 82 Yrs. 5. Social Security Number **Funeral** Days 1 XM 2 □ F October 4 011-28-4271 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show eny Injury or other traumatic event. The Machinal Examinations 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Y Yes 2 □ No N/A Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21210 USA 100 Beechdale Road Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Director Of Neurogenetics Kennedy Krieger Institute 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Werner Hugo Moser 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 100 Beechdale Road Baltimore Maryland 21210 Ann Moser/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/3/07 Lakeside Cemetery Wakefield Massachusetts 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Mustina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multisystem Organ Physician days /Medical Due to (or as a consequence of): **Examiner** SIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit signed by the attending physician and a be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed? After this certificate has 1X Yes within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, f Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Surgital Resident 29b. Signature and tifle of pertifier Clinton D. Kemp MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe Street Baltmore 600 N. M.D. D Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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-	J		-	- 1	J

			For State Registrar	-	tificate of Death		g. No.	
	×. *		Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physici /Medic		Rita G. McLaughlin			January 1		7:15P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death	4c. County of Death	
			800 Ramshead Cir.		Cockeysvill		Balti	
	Funeral Director		5. Social Security Number  490-12-2160  6. Sex 1 □ M 2 ☒ F	(In yrs. last birthday) 87 Yrs.	If Under 1 Year If Under 24  Months Days Hours	Min. 8. Date of Birth (Month, Day, Nov. 25)	Year) 9. Birthp Coun 1919 Miss	lace (State or Foreign try) Souri
	pu *		Usual Residence of Decedent  10a. State 10b. County	IOc. City, Town or Lo	cation		1	0d. Inside City Limits
	Aaryla rehor	ō	MD Baltimore	,, _ ,,				1 ☐ Yes 2X No
	28a-1	ect	10e. Street and Number	Cockeys	10f. Zip Code	10	g. Citizen of What Coun	itry?
	3a or	Funeral Director	800 Ramshead Cir.		21030		USA	
	ms 2	nera	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican,	n? (Specify Yes or No-	14. Race - Americ Black, White,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow important: If Item 27 is marked other than "natural" or 1 intelligent and intelligent and once.	by Fu	1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	1	1 ☐ Yes 2 🖾 No Specify:	delle ricari, etc.,	Specify: Whi	
Ö	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	of working	6b. Kind of Business/Ind	Justry
215	thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+		kind of work done during most of DO NOT use retired)	a voluing		
7	filed wi Hygien Sther th	Con	4	Home	maker	s Name (First, Middle, M	Own Home	
gue	be fill H of other	Be	17. Father's Name (First, Middle, Last) William E. Gauvin				alden Sumame)	
ž	should ind Men ind marke	J.	19a. Informant's Name/Relationship (Type, Print)	19b Mailie	ng Address (Street and Number	or Burke Burke	City or Town. State. Zio	Code)
Ma	d 2 s th an th an t7 is		Maureen A. McLaughlin/Daugh			Cockeysvill		
	tem 27		20a Method of Disposition	20b. Place of Dispo	sition (Name of	Date 2	Oc. Location - City or To	
Ō	Pages nent of I int: If It		1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Dulaney V Memorial	1.1.EV	anuary 23, 2007	Timonium,	MD
Baltimore,	permit. I Departm Importa any inju		21. Signature of Far and Service Lisensee		2. Name and Address of Facility emmon Funeral I	Homo of Dula		
m	Depa Impo any ii		Michael J.	Flagle 1	0 W. Padonia Ro	oad Timonium	n. MD 21093	, inc.
	Physician /Medical Examiner	er	(1412)	consequence of):	2	ardiac or respiratory arres	st,	Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	ledicai Examin	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of the c	consequence of):				
O. Box	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. ff yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
<b>a</b>	quires that n signed b uld be deta	ρ	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to th s 2 □ No 3 □ Prob	ne cause of death? pably 4 Dunknown
Vital Records,		Completed				24a. Was an autopsy perform	prior to coi death?	psy findings available mpletion of cause of 2 \( \text{No} \)
/ita	certifical	Be	25. Was case referred to medicat examiner?			of Death (Check only one	)	
<b>d</b>	Physician: this certific ral director,	J.	1 ☐ Yes 2 No Hospitaf: 1 ☐ fnpatien  27. Manner of Death 28a. Date of fnjury			sing Home 5 Resider 28d. Describe how	nce 6 Other (Specif	7)
uo	After Vune	tion	1 Natural 5 Pending (Month, Day	Year) Injury	f 28c. Injury at Work?  M 1 Yes 2 N		w injury occurred	
Division	l or Attending after death. Director: After	Certification:	2 Could not be	y - At home, farm, st (Specify)			eet and Number or Rura State)	I Route Number,
_	Hospita 4 hours Funeral	Medical Ce	29a. Certifier Check only one) Check only one) Check only one)	xamination and/or in				
	To the within 2 To the comple	Mec	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month,	Day, Year)
	- > + ō		Jusan Smelluw	W)	D4241	0.1	19/07	
	1		30. Name and address of person who completed cause of de	atri (item 23a) (Type,	11m0N1	m, mb	21093	

DHMH 17 Rev 1/2001

State Registrar

07-00509 Bonita Madden

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bonita Madden		Stat	e of Maryland / Depa			d Mental Hy	giene		
Physicia		Registrar  1. Decedent's Name (First, Middle,L		rtificate of De	eath ————		Reg	g No. 200	3. Time of Death
Medical Examir	4	BANI+A 4a. Facility Name (if not institution,	,	C. MA	de		Month January 18	Day Year 3, 2007	2117 hrs
		1329 N. Calhoun Street	give street and number)		ity, Town, or I altimore	Location of Death		4c County of Deat	h
Funeral Director		5217-15-5686 6.	Sex 7. Age (In yrs. I		Under 1 Year onths Days		-1	(MM/DD/YYYY) 9. 8i Forei 5 1979 Cc	~~
any	ļ	Usual Residence of Decedent  10a. State 10b. County		. Town or Location	-				10d Inside City Limits
<u>*</u>	tor	Md.		Ah Tin	IORE	<u> </u>			1 No 2 No
) Thours after death with the Maryland "matural", or items 23a or 28a-f show al Examiner must be notified at once.	Funeral Director	10e. Street and Number 1329 N. 0	CA/hour s		2121		10	g. Citizen of What Cou	*
r death wit or items 2 must be n	unera	11. Marital Status  1 Never Married 2 Marri	<ol><li>Was Decedent Ever in U</li></ol>	I.S. 13. Was De		panic Origin? ( Spe , Mexican, Puerto f		White, etc.	ican Indian, 8lack,
urs after tural", o	<u>a</u>	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ced If Yes, Give Year or Dates:	1 Yes	2 No		ork done	Specify 3	ACK.
, MD 21215-0036 and 2 should be filed within 72 hours after leath and Mental Hygiene ten 27 is marked other than "natural", tranmatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	f working life.	DO NOT use retire	ed)		BALTO
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name (First, Middle, La	Adden	1,7,00		18.Mother's Name	(First, Middle, M	aiden Surname	PINTO
ID 21215-1 should be filed and Mental Hyg 7 is marked oth	To Be	19a Informant's Name/Relationship	(Type, Print )		ress (Street	t and Number or Ri	ura Route Numb	per, City or Town, State	e, Zip Code)
e, MD I and 2 sho Health and item 27 is	-	Ruth Turwer  20a Method of Disposition	20b.	Place of Disposition		wood A	Date 4/0	20c. Location - City or	<i>Md-21223</i> Town, State
Pages nent of ant. If or other		8 Burial 2 Cremation  Donation 5 Other Specific	Removal from State	crematory or other pl	ace) IRME	1 /-	26-07	Dunda	Ik md
Baltime permit Pag Department Important:		8 urial 2 Cremation  4 Donation 5 Other Spec  21. Signature of Funeral Service Lic  23a Part I. Enter the displace, or cofailure. List only be cause on	Martn.	22. Name	and Address	of Facility FAST-PR	NAVE	BAL	TO. Md
Physician /Medical		. •			ode of dying,	such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	a. Gunshot Wounds (2) o						Bodin
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	of):					
cuted and transit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of d.	of):					
al an	edical	UNPENDED	x AMENDED 5 per f	h g863 1–2	23-07 v	vt			
Box 6876 e death certificate the attending phy ed for use as the b	ΣI	IF FEMALE: 23b Was decedent pregnant in the past 12 months?	23c If yes, outcome of prec	2 Fetal de	eath 3	Ectopic pregnar	псу	23d Date of deliver Month	y Day <b>Y</b> ear
Box ne death of the atten	Physic	1 Yes 2 No 9 V Unkno	9 OHKHOWH	5 Other (	(Specify)				
s, P.O. Baires that the de signed by the	ē	Part II. Other significant condition	ns contributing to death but not r	resulting in the under	lying cause g	iven in Part I.		pacco use contribute to 2 ✓ No 3 Pro	
cords,	Completed						24a. Was all autops perform	y prior to	utopsy findings available completion of cause of
tal Rec		25. Was case referred to medical			26.Place	of Death (Check o	1 <b>Y</b> Yes 2		es 2 No
'Vital hysician:	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DON	Other Nursing	Home 5 F	Residence 6 🗸 Othe	r Scene
Division of Vital Records, tal or Attending Physician: The law require rs after death al Director: After this certificate has been sited in by the funeral director, page 2 should be		27. Manner of Death  1 Natural 5 Pending 2 Accident Investig		28b. Time of Injury 2033 hrs			28d. Describe ho Subject shot	ow injury occurred	
Division ital or Attenus after death ral Director:	Certification:	3 Suicide 6 Could r 4 Homicide	not be 28e. Place of Injury - At h		ctory, office bu		or Town, Sta		ural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deached for use as the buri	Medical C	29a. Certifier 1 Certifying Phys	sician: To the best of my knowled						
To To cor.	Me	29b. Signature and title of certifier	and manner stated		29c. License			29d Date signed (Mo	
07		Tatu Uron	ca-tollar	,	O.C.N	M.E.		January 19, 200	7
3		30. Name and address of person when Patricia Aronica-Pellak I		*	1 Penn Str	reet, Baltimore	e, MD 21201		
St	ate	31 Date filed (Month Dely, pean	2007 32 Segistrar's Signat	12 Rocalis	90				

DHMH 17 Rev 1/2001

ORIGINAL

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		1	For State Registrar	State of Mary		epartment of H C <i>ertificate of I</i>			ene 0 0 7	01477
	Dhoriel		Decedent's Name (First, Middle, L	ast)		/		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	Douge		DDE		Leasting of Dooth	1 -	17 - 0 4c. County of De	7 8:30PM
	Examin	er	la Facility Name (If not institution, g Lorien Frankfor	d Nursing Hon	ıe	4b. City, Town, or	Location of Death Baltimore			
4	Funeral Director		218-52-0468	Sex 7. Age (In	Lyrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 10-22	Year) 9. B MD	rthplace (State or Foreign Country)
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
	Mary Iled	tor	MD Baltin	ore City	Baltim	ore				1 XYes 2 □ No
	h with the	al Director	10e. Street and Number 5009 Frankford	Avenue		10f. Zip Code 21206			og. Citizen of What C USA	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinating the notified at once.	by Funeral	11. Marital Status 1⊠Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: B	ite, etc.
21215-0036	within 72 ho ane. than "natur he Medical	Completed	15. Decedent's (Specify only highest of Specify only highest of Specify (0-12)	Education grade completed) College (1-4or 5+)		Decedent's Usual Occup Give kind of work done life. DO NOT use retired known	during most of workii	ng	16b. Kind of Busines <b>Unknown</b>	s/Industry
land 2	ld be filed lental Hygir ked other ic event, I	To Be Co	17. Father's Name (First, Middle, La John Morris Mado				18. Mother's Name Ella Ine	(First, Middle, N z Ringgo]		
Maryland	nd 2 shou alth and M 27 Is mar ir traumat		19a. Informant's Name/Relationship Ella Inez Madden	(Type, Print) Mother	19b. <b>4</b> (	Mailing Address (Street 09 Virginia	and Number or Rura Avenue #3	Route Number, 302 Tows	City or Town, State on , MD 21	Zip Code) 286
Baltimore,	Pages 1 annent of Heamant: If item	3.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	cemetery	Disposition (Name of c, crematory or other place peake Crema		Jan 19	20c. Location - City of Beltsville	
Balti	permit. Departnimports any inju		21. Signature of Funeral Service Lice	censee	1443	<sup>2</sup> Cremacione 8717 Green				Maryland 21286-
H			23a. Part1. Enter the disease, or or shock, or heart failure. List or	ity one cause on each fine.	0		ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a c		ancer				
	Examiner			. Chrm	T Obs	tructive Pu	monary	DISEGIE		
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c			-			
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8760,	cate be executed physician and the burial-transit	dical E		d		•				
9	tificate ig phy as the	fedic								
.O. Box	The law requires that the death certifu ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 [ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y		23d. Date of o Month	elivery Day Year
<u>α</u>	quires that I in signed by uld be deta	by	Part fl. Other significant condition $A/cche/A$	s contributing to death but r	ot resulting in	the underlying cause give	ven in Part I.			to the cause of death?  Probably 4 Unknown
I Records,		Completed						24a. Was a autops perform 1 Yes 2	y prior t ned? death	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		continut 3 DOA Ct	26. Place of Death			
o	Phys rthis raldii	. To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	28b. T	ime of 28c. Inju	ry at		ence 6 Other (S) ow injury occurred	pecify)
Ou	Attanding I rr death. ector: After by the funer	atlon	1 Naturaf 5 Pending 2 Accident investiga	(Month, Day Y	ea <i>r)</i> fr	ijury Wo	rk?  Yes 2 □No			
Division	al or Attandi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin			rm, street, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
7	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 T Certifying (Check only one) 2 Medical E	Physician: To the best of r xaminer: On the basis of ex and manner state	amination and	, death occurred at the trulor investigation, in my (	me, date and place, opinion, death occurr	ed at the time, d	ate and place, and d	ue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifie	wine,	mo	29c. Licens	se number		9d. Date signed (Mo	
			30. Name and address of person w	the completed cause of dear	th (Item 23a) (	Type, Print) H Reyal H	ve Baltin	un, mo	21217	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 3 2007	32. Registrar's	Signature	D				

		1 - State Registrar			delible Ink Ensure 31 1–23–07 vt artment of Health an rtificate of Death		Reg. No U U /	014/0
Physici /Medio	al	Decedent's Name (First, Middle, Last,			Mach	2. Date of Dea Month	19 200	01000
Examin Funeral Director	er	The Johns Hopk  5. Social Security Number  218-62-4847	sins Hosp	n yrs. last birthday) 1 Yrs.	4b. City, Town, or Location of E  Rallimore CI  If Under 1 Year If Under 24  Months Days Hours	ty	4c. County of De	rthplace (State or Foreign Country) 'Yland
oth with the Maryland 23s or 28s-f show ust be notified at	rector	Usual Residence of Decedent  10a. State  10b. County  Md •  10e. Street and Number	10	Dc. City, Town or Lo			10g. Citizen of What C	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
after dee	by Funeral Director	207 South Ellwo  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	od Avenue  12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13.	21224 Was Decedent of Hispanic Origin (Yes, specify Cuban, Mexican, P	? (Specify Yes or No	USA	erican Indian,
ified within 72 hours af I Hygiene. other than "natural; or rent, the Modical Exem	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th	cation	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired			
d 2 should be fill the and Mental Hy ?? is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last) Leon J. Mach,  19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	EVe	Name (First, Middle, elyn Voge r Rural Route Numbe	e 1 or, City or Town, State,	Zip Code)
Pages 1 an ment of Heal ant: If item 2 ury or other		Leon J. Mach, J.  20a. Method of Disposition  1 Durial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Jamoual from State	20b. Place of Dispo cemetery, crer Oak Law	n Cemetery Ja	Date <b>07</b> an 23 <del>, 06</del> H	20c.Location-City o	Town, State
permit. Departi		21. Signature of Funeral Service Licens  23a. Part1. Enter the discusse, or compleshock, or heart failure. List only or	aul	1	Name and Address of Facilik & 201 Dundalk #	aczorowsł we. Balt	ci Funera imore, M	1 Home, PA d. 21222
Physician /Medical Examiner	0	snock, or neart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Alcoholic  Due to (or as a co	Cirhosi onsequence of):	\$			interval Between Onset and Death
ate be executed thysicien and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	illure			14 days
the death certificate be evy the attending physicien eched for use as the buria	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy		23d. Date of de Month	olivery Day Year
law requires that the de as been signed by the a 2 should be deteched		Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
The ate h	Be Completed	25. Was case referred to medical examiner?			26. Place of	24a. Was a autop perfor 1 Yes	sy prior to med? death? 2.2 No 1 ☐ Ye	utopsy findings available completion of cause of s 2 No
ing Phy Mer this	ertification; To I	1 Yes 20 No  27. Manner of Death  Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury			ence 6 Other (Spe	ecify)
To the Hospital or Attending within 24 hours standed to To the Funeral Director: After completely filled in by the funeral	cai Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	pecify)	occurred at the time. Take and o	City or Tow	questel and annual	- detect
To the Ho within 24 To the Fu completely	Medic	29b. Signature and title of certifier	and manner stated.	amination and/or inv	29c. License number	eccurred at the time, o	late and place, and du	th, Day, Year)
10		30. Name and address of person who co Harisha Cook, The To	moleted cause of death	(Item 23a) (Type			Panulny 19 re, Hamilana	2007
Sta Registr		31. Date filed (Month, Day, Year)	32. Schistrar's	Signature	reils o		- tra dame	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death January 20, 2007 ear **Physician** ROSEMARY SWINDELL 4:15A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Holly Hill Manor If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day Year, March 29, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 - M XXF Maryland 213-38-5573 87 Director Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other treumatic event, the Madical Examinar must be notified at XXYes 2□No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21210 4614 Keswick Road USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐧 No 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importsnt: if item 27 ie marked other than "natural", or iten sny injury or other treumation. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Rogers Swindell Mary Wilson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael F Marlow 4614 Keswick Road Baltimore, Maryland 21210 Son 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GreenMount Crematory 1/22/07 ☐Donation 5 ☐ Other (Specify) Baltimore, Maryland \_ 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OSCa /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ettending physicien use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) deteched 9 Unknown 2 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificate funeral director, pag 1 Yes 2 No 1 ☐ Yes 2 □No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ٥ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending hours efter death. uneral Director: Aft lifed in by the fur NA 2 No investigation 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 - Homicide within 24 hours of To the Funeral L To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo 2 3 2007 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician**  $P^{M}$ 2007 Sandra Edwards Northington January 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilcrest Hospice Center Towson 8. Date of Birth (Month, Day, Year) Sept. 27 1932 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 NC 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days NC 1 ☐ M 2 💢 F 240-44-2585 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 1 ☑ Yes 2 ☐ No Timonium Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 21 Gorsuch Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [X] No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify. Baltimore, Maryland 21215-0036 Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Household unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn Gentry Edwards 2 Ross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21 Gorsuch Road, Timonium, MD 21093 Lionel F. Northington (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. Date 20 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 2007 Roanoke Rapids, NC Cedarwood Cemeterv 4 ☐ Donation — 5 ☐ Other (Specify) 21. Signalure of Funeral S 22. Name and Address of Facility Stallings Funeral Home, P.A. Mountain Road, Pasadena, MD 21122 23a. Partl. Enter the disease, or complection that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only die cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sears **Physician** /Medical s a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 | Yes To the Hospital or Attending Physician: 26. Place of Death Check onl one funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence Hospital: 61 Other (Specific 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 27. Manner of Death Injury 1. Natural 5 ☐ Pending investigation 1 TYes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Janumy 17, 200) 0 Charly St. Belto, and Z1204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 mo 31. Date filed (Month, Day, Ye.

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU / 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year SUSAN ANDERSON NASH JAN 17 2007 10:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 306 Normandy Drive Silver Spring MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan. 17, 7. Age (In vrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 1 ☐ M 2 🖫 F Months Hours Year 303-48-4867 Director 60 1947 Illinois Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location show 10d. Inside City Limits item 27 is marked other than "naturef", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ∏Yes 2 N No Maryland | Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 306 Normandy Drive 20901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature", or item any injury or other traumatic evant. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: 3 ☐ Widowed 4 St Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kindergarten Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellis Clarence Anderson ၀ Roxanna Erickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth N. Kennedy / Daughter 306 Normandy Drive, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. Date 21. 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2007 Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. -M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List pnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 led by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☑ Yes 2 □ No 24a. Was an autopsy performed? 1 XYes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0032598 JAN 19 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER Michael J. Birrer, MD BETHESDA MD 20889-5600

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 3 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Constance E. Orem P M January 2007 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1005 Wheatfield Dr. Millersville Anne Arundel 8. Date of Birth (Month, Day, Sep 30, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year) 1942 Months 212-44-3026 1 □ M 2 🖼 F Days Hours Min. Maryland 64 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hylgineo. ant. If them 27 is anarked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel Director Millersville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1005 Wheatfield Dr 21108 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Good Shepherd Center Medical Records Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Ripke Delores Sohn 2 19a. Informant's Name/Relationship (Type. Print)
Leslie Spangler, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Wheatfield Dr Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory Inc. 1/18/07 Department of Important: If It any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring 22 Name and Address of Facility
Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Lach 23a. Part1. Enter the disease, or comptreations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastati Sarcom disease or condition resulting in death) 6mi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) the 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown auto s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 certificate has autopsy perform 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Nary Tankan 1310P Owens 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MIVERSITY U Mary and Med Social Security Number | 9. Sex | 7 val MUVR N/A If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1□ M 2 □ F Months Hours Min. 217-34-3507 68 Director 17,1938 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10h. Count Show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 In No УVd Baltimore wings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes, Solve
Year or Dates: 9020 Amb USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beauty 10 +4 Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Bozue Grant verro Grant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cliza Brown Amber Dah way bate Son Dwens groll 9020 Cwings Wills Wd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) King Mem PK Cemetery Randallstown 27/07 21. Signature of Funeral Service Licensee Charman Harris Funeral Home 22. Name and Address of Facility Baltimore 5240 Reisterstown 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hronic obstructive Dulmonary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 pronths?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) the a funeral director, page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) spital: 1 Inpatient 2[ 28a. Date of Injury (Month, Day Year) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the Director: Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASORO Lise 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

State

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

	1	For State Registrar	State of Maryla		rtificate of D			eg. No.	7 (	)   485
Dhysisian		1. Decedent's Name (First, Middle,					2. Date of Dea Month		ear	Time of Death
Physician /Medical		Joseph Harold O	ndrovik Sr.				1	19 200	7	7:56 A M
Examiner		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or L	ocation of Death		4c. County of	Death	
		Baltimore Washi		Ctr	Glen Bur			1	Arund	
Funeral Director		217-26-1413	6. Sex 1 M 2 □ F 85	rs. last birthday) Yrs.		Il Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10-3-19	Year) 9	Birthplace Country) MI	(State or Foreign
72 hours after death with the Maryland natural; or itema 23s or 28s-1 show digal Examinar coust be notified at about by Funeral Director	-	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. i	nside City Limits
dary fah	5	MD Anne A	runde1	Gambril:	ls					I ☐ Yes 2 🕅 No
riter death with the Mar ritama 23a or 28a-1 ab diner must be notified	2	10e. Street and Number			10f. Zip Code		,	Og. Citizen of Wha	at Country?	
30 0	5	217 Nashua Cour	t		21054			USA	-	
Ta 2	<u> </u>	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No-		American II	ndian,
		1 ☐ Never Married 2 【 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  ad 1 Tes 2 No  If Yes, Give  Year or Dates:		if Yes, specify Cuban, 1 ☐ Yes 2 🛣 No		tican, etc.)	Specify:	White, etc. Whit	e
te leaf	200	15. Decedent's (Specify only highest	s Education	16a. Dece	dent's Usual Occupation	on ring most of working		16b. Kind of Busin	ess/Industr	у
a Para	5	Elementary/Secondary (0-12)	College (1-4or 5+)	iife.	kind of work done dui DO NOT use retired)	ang most of works	,	Columbia	D., L. L.	C
d other then "natural", c event, the Medical Exar Re Completed by	5	12			Sales			Columbia	Kubbe	r corp.
to the day	0	17. Father's Name (First, Middle, L.			1	8. Mother's Name	(First, Middle,	Maiden Sumame)		
a S	2	Frank	Ondro	vik		Hilda				
		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ng Address (Street and	d Number or Rurai	Route Number	r, City or Town, Sta	te, Zip Coo	(e)
itam 27 other tra	- 1-	Mrs. Norma Ondro			Nashua Cou					
r oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 DRamoval from State	<ul> <li>b. Place of Disposition cemetery, creations</li> </ul>	sition (Name of matory or other place)	D		20c. Location - Cit	-	
nu A		4 Donation 5 Other (Sp.	ecify)	nesapeak	e Crematio	$n \mid 1/22$	/2007	Stevensv	ille,	MD
any injudence.		21 Signature of Funeral Service Li	M013	h/1	2. Name and Address Second AV		gleton Burni	Funeral e MD 2106	Home	P.A.
physicien and sine burial-transit aminer street aminer sedical Examiner	E 1	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ATTHERE D  Due to (or as a cons  b. Due to (or as a cons  c. Due to (or as a cons  d.	sequence of):		, 1,10,10	77130			YEART
or use a	alcial ivini	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	l delivery Day	Year
ched f	>									use of death?
detached f		Part II. Other significant condition	s contributing to death but not	resulting in the u	nderlying cause given	in Part I.	23e. Did to	bacco use contribu	ite to the ca	
n signed by the ettending phy lid be detached for use as the detached for use as the detached by Physician/Med	מווא ביווא		ns contributing to death but not MEULITUS			in Part I.			ite to the ca	4 Unknown
hould hould	iered by riny					in Part I.	1 🗆 Y	9s 2□No 3[	☐ Probably	
20 0	mipleted by rilly					in Part I.		n 24b. We	Probably re autopsy f	4 Unknown indings available tion of cause of
20 0	Completed	DIABETES			2		1 Tyes	n 24b. Weisy prio dea	Probably re autopsy f	indings available tion of cause of
20 0	na combiere	DI ABETES  25. Was case relerred to medical examiner?	MELLITUS	TYPE	2	6. Place of Death	1 Yes	n 24b. Wei prio med? dea 2 No 1	Probably re autopsy for to completh? Yes 2	indings available tion of cause of
20 0		25. Was case relerred to medical examiner?  1  Yes  2  No  27. Manner of Death	MEULITUS  Hospital: 1   Inpatient 2	TY/C	2 nt 3 DOA Other	.6. Place of Death 4 ☐ Nursing Horr	24a. Was a autops perfori 1 Yes  (Check only onle 5 Reside	n 24b. We prio dea 27 No 1   24b. We prio dea 27 No 1   3   3   3   3   3   3   3   3   3	Probably re autopsy for to completh? Yes 2	indings available tion of cause of
After this certificete hes funeral director, page 2 lon; To Be Comp		25. Was case referred to medical examiner? 1  Yes  25 No 27. Manner of Death 1 Matural  5 Pending	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year	ER/Outpatier	at 3 DOA Other.  f 28c. Injury a Work?	16. Place of Death 4 \( \text{Nursing Hom} \)	24a. Was a autops perfori 1 Yes  (Check only onle 5 Reside	n 24b. Wei prio med? dea 2 No 1	Probably re autopsy for to completh? Yes 2	indings available tion of cause of
After this certificete hes funeral director, page 2		25. Was case relerred to medical examiner?  1  Yes  2  No  27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatier 28b. Time o	at 3 DOA Other:  ### 28c. Injury a Work? ### 1 Ye	16. Place of Death  4 □ Nursing Horr  t 2  s 2 □ No	24a. Was a autops performed in Yes (Check only on the 5 Reside Bd. Describe house)	n 24b. We prio dea 22 No 1 Dep 24b. We prio dea 22 No 1 Dep 25 No	Probably re autopsy for to comple th? Yes 2  (Specify)	indings available tion of cause of No
After this certificate has funeral director, page 2 lon: To Be Comp	Celuication, 10 de Completed	25. Was case relerred to medical examiner?  1	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year	28b. Time o Injury  at home, larm, streedity)	at 3 DOA Other.  If 28c. Injury a Work?  M 1 Ye reet, factory, office	16. Place of Death  4 Nursing Hom  t 2  s 2 No 2	24a. Was a autops perform of the Solid Residual Control of the Con	n 24b. We prior dea 22 No 1 De 1 De 1 De 1 De 1 De 1 De 1 De 1 D	Probably re autopsy if to complete r to complete Yes 2  (Specify)	indings available tion of cause of No
After this certificate hes funeral director, page 2	edical certification, 10 be completed	25. Was case relerred to medical examiner?  1   Yes   2   No  27. Manner of Death  1   Natural   5   Pending investigal investigal determine  2   Accident   6   Could not determine  29a. Certifier   1   Certifying (Check only 2   Medical E	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year ation 28e. Place of Injury - A building, etc. (Spe	28b. Time o Injury  at home, larm, streedity)	at 3 DOA Other.  If 28c. Injury a Work?  M 1 Ye reet, factory, office	16. Place of Death  4 Nursing Hom  t 2  s 2 No  2  date and place, are ion, death occurre	24a. Was a autops performed in the second of	n 24b. We prior dea 22 No 1 De 1 De 1 De 1 De 1 De 1 De 1 De 1 D	Probably re autopsy ( r to complete r to complete Yes 2  (Specify)  or Rural Role er as stated due to the	indings available tion of cause of No
within 24 hours effer death.  To the Funeral Diractor: After this certificate has been signed by the e completely filled in by the funeral director, page 2 should be detached to Medical Certification: To Be Completed by Physician	medical certification, 10 de completed	25. Was case relerred to medical examiner?  1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year ation of the hed 28e. Place of Injury - A building, etc. (Special Physician: To the best of my Interpretated).	ER/Outpatier  28b. Time o Injury  At home, larm, str ecify)  knowledge, deat	at 3 DOA Other.  In a DOA Other.  See Injury a Work?  M 1 Ye reet, factory, office  h occurred at the time, vestigation, in my opin  29c. License n	16. Place of Death  4 Nursing Hom  t 2  s 2 No 2  date and place, a ion, death occurre	24a. Was a autops performed in the series of	n 24b. Wein prior dea 22 No 3 State)  24b. Wein prior dea 22 No 1 State	Probably re autopsy (r to complete for to complete) Yes 2 Specify) or Rural Role are as stated due to the	indings available tion of cause of No  No  ute Number,  cause(s)
After this certificate hes funeral director, page 2	medical certification, 10 de completed	25. Was case relerred to medical examiner?  1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year ation of the hed 28e. Place of Injury - A building, etc. (Special Physician: To the best of my Interpretated).	ER/Outpatier  28b. Time o Injury  At home, larm, str ecify)  knowledge, deat	at 3 DOA Other.  In a DOA Other.  See Injury a Work?  M 1 Ye reet, factory, office  h occurred at the time, vestigation, in my opin  29c. License n	16. Place of Death  4 Nursing Hom  t 2  s 2 No 2  date and place, a ion, death occurre	24a. Was a autops performed in the series of	n 24b. Wein prior dea 22 No 3 State)  24b. Wein prior dea 22 No 1 State	Probably re autopsy (r to complete for to complete) Yes 2 Specify) or Rural Role are as stated due to the	indings available tion of cause of No  No  ute Number,  cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend #20b, perFH, 27, perME, g863 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Month 6:25a M 01 13 Olga Obrams 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Rockville Shady Grove Hospital 7. Age (In yrs. last birthday, 91 vrs If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months 1 □ M 2X I Latvia 06-17-1915 219-42-2551 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 20 No Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 USA 402 Hurley Ave #302 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🔀 No Specify. Specify: 3 ★Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Karlis Baltins Marlja Zommers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Gunta Iris Obrams/daughter 13408 Valley Dr. Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 1/19/2007 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac prespiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mont 3 days Right Femoral Fracture Due to (or as a consequence of): Due to (or a a consequence of) Due to (or as a consequent of) IF FEMALE: 23b. Was decedent pregnant

**Physician** /Medical Examiner

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Beral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital o within 24 hours aff To the Funeral D

Physician/Medical

Completed by

Medical Certification: To Be

25. Was

Division or Vital Records, P.O. Box 68760

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show r 28a-f show notified at

ms 23a or

r than "natural", or items the Medical Examiner mu

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or item any injury or other traumatic event, the Medical Examples.

Baltimore, Maryland 21215-0036

MD

Director

Funeral

\$

Completed

Be

2

with the Maryland

death

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner

in the past 12 months?

1 ☐ Yes 2√No

9 Unknown

4 ☐ Homicide

29a, Certifier

Þ

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3 □Ectopic pregnancy

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

6 ☐Other (Specify)

13,2007

1 Tyes 2 No 3 Probably 4 Number 1 Probably 4 Number 1 Probably 4 Number 2 No 3 Probably 4 Number 2 Nu

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9□Unknown

4□Pregnant at time of death

Hypertension, Dehydration, Urinary Tract Infection

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes AND No

Was case referred to medical			26. Place	of Death (CI	heck only one)	
examiner? 1XYes 2□No	Hospital: 1 ☑ Inpatient	2 ER/Outpatient	3 □ DOA Other: 4 □ Nu	rsing Home	5 Residence	6 □Other (
Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at	28d.	Describe how inju	ury occurred

27. Mann (Month, Day Year) 5 | Pending 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide

110/2007 1 ☐ Yes 2 No 6:40M Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD

TRIPETELL IN KITCHEN 281. Location (Street and Number or Flural Route Number, A City or Town, State) 462 Harley Hu 30 Rockwille, Mb 20350

Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 053654 Januam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Center Drive Rockway mo 20850 9901 HO-YAU 21 31. Date filed (Month, Day, Year)

5 ☐ Other (specify)

State Registrar

§2. Registrar's Signature JAN 2 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 19, 2007 12:30P M Physician DALE OBAKER SHANNON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 19,1977 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M Mary l'and 29 219-08-5238 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 □ Yes 2√No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 USA 506 Anneslie Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status 1 XX Never Married 2 ☐ Married White 1 ☐ Yes **次**No Specify: altimore, Maryland 21215-0036 ۵ 3 Widowed 4 Divorced 16b Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professional Baseball Team Director of Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Jane Lytle Rodney Dale Obaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 506 Anneslie Road Baltimore, Maryland 21212 Mother Mary Jane Obaker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2**XX** Cremation 3 □Removal from State GreenMOunt Crematory 1/22/07 Baltimore, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral Ferrice Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) concer CAL ervi Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate eaus. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 26. Place of Death Check onl one 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Naturai 1 □ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUARY 19,2007 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) N. Charlos St. Balto. Md 2120x 6701

Registrar

State

31. Date filed (Month, Day,

Year)

3 2007

3 M C 670 3 Rigistrar's Signature 07-00539 Kwang Jun Park Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 8 per 11, 28, 407dhb

		- For State All CINI .	reem o per Gen	ncale o	Dean					eg. No.		
Physicia Iedical Exami	n/	i. Decedent's Name (First, Middle,Last)  Kwang Jun Park						2. D M Ja	Date of Deat Month anuary 20	Day 0, 2007	Year	3. Time of Death 0306 hrs
men of the		4a Facility Name (if not institution, give	treet and number)		4b. City, Tov Ellicott		ocation of D	Death		4c. Coul	nty of Deat ard	h l
,		Rt. 29 South / Rt. 40  5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under		If Under 2	24Hrs. 8.	Date of Bir	th(MM/DD/Y		rthplace (State or
Funeral Director				Yr	Months	Days	Hours	Min.	)2/05/ 7/27/1	<b>1961</b>	Enroi	<sup>gn</sup> <sup>Duntry)</sup> S. Korea
		219-35-6293   1x   Usual Residence of Decedent	1 2 F 45						721/1			
any		10a. State 10b. County	10c. City, 1	Town or Loca	ition							10d. Inside City Limits  1 Yes 2 X No
daryland 28a-f show any <u>d at once.</u>	5	MD Howard	Elli	.cott (								
Maryla 28a-f d at o	Director	10e Street and Number			10f. Zip C				1	0g. Citizen o	t vvnat Col	untry?
with the Maryland ns 23a or 28a-f sho be notified at once.	٥	3424 Harrington D		140 W	21 as Decedent	042	onio Origini	2 / Specifi	v Ves or No	U.S.	Pace - Ame	rican Indian, Black,
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5-0036 lled within 7 Hygiene I other than	E .	12 17. Father's Name (First, Middle, Last)		Sales	Manag		3 Mother's	Name (Fir	rst, Middle,	Maiden Surn	Tradi	iig
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10re, Mages 1 and 2 nt of Health it: If item 2 other traum		1 X Burial 2 Cremation 3	Removal from State	rematory or o	other place)					,		140
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Fun 1 I Service Licens			Memoria Name and A			1/22,	/07/	Elkr	idge,	MD
Baltimo permit. Page Department Important:		. 11 .		Ga	rv I.	Kau	fman :	Fune	ral_H	ome @ 1	MMP,	Inc.
Physician		23a Part I, Enter the disease, or compl	cations that caused the death.	Do not enter	The mode of	dying, s	uch as car	rdiac or re	spiratory at	rest. short	of heart	r imate Interval Between Onset and
/Medical		failure. List only one cause on ear Immediate Cause (Final disease a.	Multiple Injuries									Death
Examiner		or condition resulting in death)	ue to (or as a consequence of	F):								
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8760, tificate bung physic as the bun	/Me	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of preg		Fetal death	3 [	Ectopic	pregnancy	v	23d. Da Mor	ate of deliventh	ery Day Year
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Box e death c the atten	Physicia	1 Yes 2 No 9 Unknown	9 Unknown		deal for		i ia Dao	* I	23e Did	tobacco use	contribute	to the cause of death?
- ± 5-5	by P	Part II. Other significant conditions	contributing to death but not r	esulting in th	e unaeriying	cause g	iven in Far	tt.				robably 4 Unknown
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D ospital hours ineral		4 Homicide  29a. Certifier 4 Certifiers Physics	an: To the best of my knowled			timo de	ate and pla					
Division of Vital Records, P.O  To the Hospital or Attending Physician: The law requires that within 24 hours after death To the Funeral Director: After this certificate has been signed to commission filled in by the funeral director, page 2 should be deta	ledical	(Check only one) 1 Certifying Physic 2 Medical Examine	On the basis of examination:	and/or investi	igation, in my	opinion	, death occ	curred at t	the time, dat	te and place,	and due to	the cause(s)
To Wit	Me	29b. Signature and title of certifier	and manner stated.		290	. Licens	e number			29d Dat	e signed (	Month, Day, Year)
		Washinte D	ne Whell			O.C.	M.E.			Janua	ry 20, 20	007
7		30. Name and address of person who	completed cause of death (Iter		Penn Str	eet D	altimore	MD 21	1201			
			SSISTANT MEDICAI EXAMI		A A			·, will 2				
Regi	State stra	INDIA 3		15 /4	and I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** PASE P GLORIA JANUARY 18,200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** 1 □ M 250 F Q19 32 1842 Usual Residence of Decedent ARY APR.I Director 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Yes 2□No Director BALTIMORE MARILAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 4320 BZR65R 21206 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: ò WHITE 9€ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". College (1-4or 5+) Elementary/Secondary (0-12) omenak AT HOME 13765 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3320 Garnet rd. Parkville, mp 21234 JAMIS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition JANAY ↑ Burial 2 Cremation 3 Removal from State GARRISON FORUST GARRISON 4 □ Donation 5 □ Other (Specify) 2007 22. Name and Address of Facility

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28. Na 21. Son were of Fune of Service License EXUZ ENTUUT ROW BULL AND FULL AND FULL AND FULL AND FULL AND THE AND FULL A X row 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTILOBAR PNEUMONIA 5 days **Physician** /Medical Due to (or as a consequence of): Examiner 2 months COLL ALUTE LYMPHOID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has the lirector, page 2 s autopsy performed? Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 5E 100 2 ER/Outpatient 3 DOA 1 ☐ Yes After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Da 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 RUPAL MALANI, MEDICAL DOCTOR JANUARY 18, 2007 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUPAL MALANI, THE JOHNS HOPKINS HOSPITAL, 600 NOTTH WOLFE STREET, BALTYMORE MARYLAND ZUZT

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

State Registrar

DHMH 17 Rev 1/2001

Box 68760.

Memorial

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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JAN 2 3 2007

31. Date filed (Month, Day, Year)

Jan. 19, 2007

Hospital, Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard August Poehlman 9:00 ам 01/17/2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5924 Charnwood Road Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **№** M 2□F Hours Director 86 07/30/1920 New Jersey 214-03-5126 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Baltimore Catonsville Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 5924 Charnwood Road United States 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Auto Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Poehlman Jean Wasseram 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Poehlman (Daughter) 8 Dunbar Avenue, Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 01/20/2007 Baltimore, Maryland 5 Other (Specify) 22. Name and Address of Facility of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) prostate cancer **Physician** ayears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tran Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOS7436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 cours Avenue Boutmore 110 21229. Heather D. Mannuel nus

Registrar

State

31. Date filed (Month, Day, Year)

JAN 2 3 2007

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 11. Q 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 105 08:50 2007 January 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore University Margland Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 KF **Director** 164-05-4943 96 PA 08/28/1910 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1XIYes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 105 West Conway Street 21201 72 hours after death Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X** No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7, th and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) <u>Administration</u> College Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter A. de Alejos <u> Harriet Nelson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any Injury or other trau 105 West Conway Street, Baltimore, Maryland 21201 Eugene Pillot (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) West Laurel Hill 01/22/2007 Bala Cynwyd, PA. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** 3 necks /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 mort Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the detached 9□Unknown rate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate I 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 D Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. the 29b. Signature 29d. Date signed (Month, Day, Year) d title of certifier

DHMH 17 Rev 1/2001

State

Registrar

10

address of person who completed cause of death (Item 23a) (Type, Print)

nwame

31. Date filed (Month, Day, Year)

JAN 2 3 2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		artment of H		nd Mental Hy		007	01494
			Decedent's Name (First, Middle, Last)					2. Date of De	Reg. No.		3. Time of Death
	Physici		Francis Isaih	Pogue				Jan.	Day 07 20	007	1:30p M
The same	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of E	1		ounty of Death	11.30p
	Exami		109 Cherry Hil:	l rd		Baltimo	ore				
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th Year)	9. Birth	place (State or Foreign
	Director		248-10-8482	M <sup>M 2□F</sup> 88	Yrs.	Months Days	Hours I	Min. (Month, Da 04-1	6-19	18 s.C	ntry)
	g ,		Usual Residence of Decedent  10a. State 10b. County	10a Cit.	, Town or Lo						
	aryla shor	5									10d. Inside City Limits 1 Yes 2 □ No
	Me M	Director	MD	Ва	altio						
	with a		10e. Street and Number			10f. Zip Code			_	en of What Cou	ntry?
	hours after death with the Maryland tural; or Items 23a or 28a-f show al Examinant be notified at	Funeral	109 Cherry Hil	Lra 12. Was Decedent Ever in U.S	3 12 1	21225	ienanie Origin	? (Specify Yes or No	USA	Race - Ameri	can Indian
	iter d	Ę.	11. Marital Status 1 Never Married 2 Married	Armed Forces?		f Yes, specify Cuba	n, Mexican, P	Puerto Rican, etc.)	,	Black, White,	
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21215-0036	d within 72 hours after death with the Marylar plane. Jane. Than "natural", or liems 23a or 28a-f show tra Medical Exactinat must be rollified at		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/In	
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<u> </u>	should be nd Menta marked umatic ev	ဥ	Frank A. Pogue					n A. McD			
Maryland	~ a		19a. Informant's Name/Relationship (Ty					or Rural Route Numb			o Code)
	is 1 and 3 if Health liem 27 other tri		Francina Moren		March Committee		n Ave	Baltimo			
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Ē	t. Pa tmen tant: tant:		4 □Donation 5 □Other (Specify)		ownsv			-16-2007			e MD
Baltimore,	permit. Pages Depertment of I Important: If Its eny injury or o		21. Signature of Funeral Service License	90	W	esley Cl	navis	Jr Fune	ral H	HOme	
	40204		23a. Part1. Enter the disease, or compli	cations that assumed the death	2	007 Eas	tern /	Ave Balt	imore	e MD 2	1231 Approximate
1			shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.					11651,		Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	dial	- Inf	gretz	011			
	Examiner			Due to (or as a consequ	ence of):	·					
		er	Secuentially list conditions if any, leading to immediate	Due to ( a a consequ		01)					
	uted ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	exec an en rial-tr	Еха	resulting in death) Last	Due to (or as a consequ	ence of):						
8760	cate be executed physician end the burial-transIt	dicai		l							
9	nifica ng ph as th	Medi	15 F5144 F								
Вох	death certifi e ettending I ed for use as	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23	d. Date of deliv	
	he ett	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown		Other (specify)				Month	Day Year
<u>о</u> .	at the	Physician/Me	9 Unknown								
	The law requires that the de ste hes been signed by the c bage 2 should be detached i	ρ	Part II. Other significant conditions cor	itributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.				he cause of death?
Vital Records,	w requir been si should	Completed			·		-		Yes 2	No 3 Prot	bably 4 Danknown
ec	a law	nple	-					24a. Was	DSV	24b. Were auto prior to co	opsy findings available impletion of cause of
<u> </u>		S	2.330					1 ☐ Yes	2 No	death? 1 🗌 Yes	2 No
Ž	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		100		Death (Check only			
	Phys this ral dir	٩	TO THE ZINO		R/Outpatier		4 LI MUISI	ng Home 5 PAes			fy)
ב	ing After une	lo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl		28d. Describe	now injury	occurred	
Division of	Attending Physician: Ir death. ector: After this certific by the funeral director,	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm str		Yes 2 ☐ No		Street and	Number or Rus	al Route Number,
_	2 2 2 2	Certification;	4  Homicide determined	building, etc. (Specify	)	eet, factory, office			wn, State)	rvanioer or Hare	ai noate ivamber.
	splta ours ours filled		29a. Certifier 1 Certifying Phys	sician: To the best of my know	viedge, deat	h occurred at the fin	ne, date and r	place, and due to the	cause(s) a	nd manner as s	stated.
	To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Examinations)	ner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my of	pinion, death	occurred at the time,	date and p	lace, and due t	o the cause(s)
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	0		I write Us	The state of the s		Do	0524	90	Jan	1/12,	2007
	2		30. Name and address of person who co		23a) (Type,	Print)		- L	2 . 11	2.5	2007 MD 21223
				de high no		1. S. HO	inove	Y 51 · /	54112	mre	NID 2123
	Sta Benisti		31. Date filed (Month) Day, (Year)	32 Registrar's Signat	Ture	CAPED .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month I. Decedent's Name (First, Middle, Last) January 18, 2007° 7:00 PM **Physician** Wayne Harry Rathgeber /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 1338 Saratoga Drive Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M M 2 □ F Feb. 22, 1939 Baltimore, MD Director 213-38-7431 67 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Integral and marked of years and are the season of thems 23a or 28a-f show other transmission of the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Harford Bel Air Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 USA 1338 Sratoga Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🏋 No SpecifiWhite Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Coastquard Yard d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Shop Planner N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Rathgeber Evelyn Dotson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 1338 Saratoga Drive Bel Air, MD 21014 Antionette Rathgeber- Spouse Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If Its any injury or o 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BelAir Memorial Gardens 1/22/2007 Bel Air, MD 22. Name and Address of Factivans Funeral Chapel& Cremation Services 21. Signature //Funeral Service License Bel Air 3 Newport Drive Forest Hill, MD 21050 est P #11. Enter the disease, or commercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque to Examiner Sequentially list conditions, if the property of the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed siclan and burial-trans Due to (or as a consequence of): Box 68760. physiclan s the burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9□Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown hnord 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 1□ Yes 2□ No this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death

1 Natural

2 □ Accident After 1 Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Hospitai Eqritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Undedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) This Hopkins Julamore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** М Jan graydon 000 6 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Healthand he habilitation lenter Year If Under 24 Hrs. Sex 12 M 2 F 9 Birthplace Country) (State or Foreign **Funeral** Days Hours 164-22-399, Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow **ehow** 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or Items 23a or 21015 Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned 3 No 1 Tes 2 PYes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 other Item 27 is marked other other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 is marked other. Be -lorence 19a. Informant's Na e/Relations p (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BelAir 1144 Starmount Cour t, 20c. Location - City or Town, State 20b. Place of Disposition (Name of complete, crematory of other place) Date 20a. Method of Disposition ō = 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If eny injury or once. torest Hill. 21. Signatur of Funeral Se 22. Name and Address of Facyling R. FOREST HILL, MD 23a. Part 1. Enter the disease or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Evans Fuveral Chapel + Cremation Services-Belter Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** days resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien for use as the buria Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2. No 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has blirector, page 2 s autopsy performed? 2 2 No 1 Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) <sup>o</sup>L 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2√2 No 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tyes 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 THomicide 24 hours a pellij Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DZEZ

State Registrar

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760,

Vital

Division of

31. Date filed (Month, Day, Year) 32. Registr

KHUSLA

30. Name and address of person who completed cause of death (Item 23a (Type, Print)

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 10:45 Р. м WEBSTER ROUSE LEITCH JANUARY 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 08-11-1940 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **X** M 2 □ F Days 219-38-3783 66 Yrs MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD. BALTIMORE 1 ☐ Yes XX No TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 MILLDAM ROAD 21286 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. VIVes 2 No 62 If Yes, Give Year or Dates: 1968 1XXNever Married 2 ☐ Married 1 ☐ Yes XX No Specify Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ROUSE PROCESS SERVICE **PRESIDENT** YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN ROUSE, II EVA G. MARY LEITCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NANCY R.ROUSE (SISTER IN LAW) 201 EDGEVALE ROAD, BALTIMORE, MARYLAND, 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 01-20-2007 TOWSON, MARYLAND, 21204 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 YORK (R. G. RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Veurricular 30 mus Due to (or as a consequence of) WMADSTIVE ear Due to (or is consequence of): ari ISEASE IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Ves 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 1☐ Yes XX No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

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Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director,

To the Hospital within 24 hours a To the Funeral I

certificate be executed

Box 68760,

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Vital Records,

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Division

Physician:

**Physician** 

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Physician/Medical

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Registrar

7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

within 72 hours after

d 2 should be filed within the and Mental Hygiene.

Pages 1 and 2 ment of Health a tant: If Item 27 Is

permit. Pages Department of Important: If It any injury or o

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner? XX No 1 ☐ Yes

27. Manner of Death

1)(X)Natural 5 ☐ Pending investigation 2 Accident 3 ☐ Suicide

4 | Homicide

29a. Certifier

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

and mannerstat

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? М

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

ente 222 Balterione 21210

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 22334

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) JANUARY 18, 2007

address of person who completed cause of death (Item 23a) (Type, Print 30. Name an

31. Date filed (Month, Day, JAN23 2007 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2 Date of Death . Decedent's Name (First, Middle, Last) **Physician** 11:00 A Jan. 21 2007 Deborah Anne Roy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore 3717 Clarenell Road 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours **Funeral** 1 □ M 2√2 F Virginia 22, 40 Jun. 1966 219-76-5189 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show notified at 1 ∏Yes 2 ☐ No Director Maryland n/a Baltimore 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be r 21229 USA 3717 Clarenell Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Vear or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mfq. 0 Receptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Elizabeth McCloud James Melvin Roy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8337 Sail Court, Pasadena, Maryland 21122 James Roy / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 4 Donation 5 Potential Service Licensee Signature of Funeral Service Licensee 122. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MELANOMA METASTATIC **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2□ No 1∐ Yes 2 1 ☐ Yes certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 ☐ Yes 1 Inpatient Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury After (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: /
filled in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALT ST AGNES COLE MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 Age

DHMH 17 Rev 1/2001

Registrar

JAN 2 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RICHMONL Month Day Physician J44145 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner BALTIMORE 21208 2 POMONA EAST - APT. #501 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**M** 2□F Months Days Hours 218-01-4007 MD 91 06/08/1915 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location r 28a-f shov notifled at 1 ∐Yes 2**V**∏No BALTIMORE BALTIMORE Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or ? must be r 21208 2 POMONA EAST - APT. #501 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 WHITE Specify. þ 3 Widowed 4 □ Divorced 'natural", Completed other than "natur vent, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **JEWELRY** PROPRIETOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental h RICHMOND LENA **POTTS ISADOR** ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deportment of Health ar Important: If Item 27 is any njury or other trauons - ALLEGHENY AVENUE - TOWSON, MD 21204 CAROL ROZENCWAIG / DAUGHTER 527-A 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BNAI ISRAEL CONG 01/21/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u> 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last disvasular discon Examiner Il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

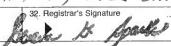
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury 28b Time of 27. Manner of Death 28d. Describe how injury occurred (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifie D1628T 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERSON ON OSCILORY, PID), ISSP CERITORE TRIFED. S. 300

State Registrar

31. Date filed (Month, Day, Year)



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# Baltimore, Maryland 21215-0036

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year **ELEANOR** ROSENBERG 4:20 AM anuary 2007 /Medical 18 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 01/31/1931 Birthplace (State or Foreign Country) Funeral Days Months Hours 1 □ M 2 👿 F 025-26-0389 75 WV Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ✓ Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3908 N. CHARLES STREET #801 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No WHITE Specify 9 Specify: 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VOLUNTEER FUND RAISING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISRAEL KANTOR RACHEL COHEN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD ROSENBERG / SON 10529 PARK HEIGHTS AVENUE - STEVENSON, MD 21153 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HILLTOP SERVICE CORP. 01/22/2007 TOWSON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** >20 years Multiple Sclevosis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) 9 Unknown has been signed by ge 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1□ Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b Time of Certification: Injury at Work? 28d. Describe how injury occurred 1 Matural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 January 18, 2007 nanithan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital Asha Manonar MO Union 2. Registrar's Signature 31. Date filed (Month, Day, Year, State JAN 2 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene